DISSERTATION
ON

"ASSESS THE MATERNAL PSYCHOSOCIAL ADAPTATION AMONG HIGH RISK PRIMI AND MULTIGRAVIDA MOTHERS ADMITTED IN ANTENATAL WARDS AT INSTITUTE OF OBSTETRIC AND GYNAECOLOGY,

CHENNAI – 8."

MSc., (NURSING) DEGREE EXAMINATION

BRANCH –III OBSTETRIC AND GYNAECOLOGICAL NURSING

COLLEGE OF NURSING

MADRAS MEDICAL COLLEGE, CHENNAI-3

A dissertation submitted to

THE TAMILNADU DR. M.G.R. MEDICAL UNIVERSITY, CHENNAI-600 032.

in partial fulfillment of the requirements for the degree of

MASTER OF SCIENCE IN NURSING

APRIL -2012

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Approved by Dissertation Committee on

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Clinical Speciality Guide

_____

Mrs. ALPHONSA MASCHRENAS, MSc., (N).
Lecturer, Department of Maternity Nursing,
College of Nursing,
Madras Medical College,
Chennai – 600 003.

Medical Expert

_____

Dr. M. MOHANAMMBAL, M.D., D.G.O.,
Director, Institute of Obstetric and Gynaecology,
Government Hospital for Women and Children,
Chennai- 600 008.

Statistical ___ **Guide**

_____
Mr. A. Vengatesan, MSc., M Phil., PGDCA (PhD),
Lecturer in Statistics,
Department of Statistics,
Madras Medical College,
Chennai- 3

A dissertation submitted to

The Tamilnadu Dr. M.G.R. Medical University, Chennai

in partial fulfillment of the requirement for the degree of

MASTER OF SCIENCE IN NURSING

APRIL 2012

CERTIFICATE

This is to certify that this dissertation titled, "**Assess the maternal psychosocial adaptation among high risk primi and multigravida mothers admitted in antenatal wards at Institute 0f Obstetric and Gynaecology, Chennai – 8"** is a bonafide work done by Mrs. K. THIRUPURAVALLI, College of Nursing, Madras Medical College, Chennai – 3, submitted to the Tamilnadu, Dr. M.G.R. Medical University, Chennai in partial fulfillment of the University Rules and Regulations towards the award for the degree of Master of Science in Nursing, Branch-III, Obstetrics and Gynaecological Nursing under our guidance and supervision during the academic period from 2010 – 2012.

Dr. Ms. R. LAKSHMI, MSc., (N), Ph.D.,
Dean,
College of Nursing,
Madras Medical College,
Chennai- 600 003.

Prof. Dr. V. KANAGASABAI, M.D. Principal,
Madras Medical College,
Chennai -600 003.

ACKNOWLEDGEMENT

My heartfelt gratitude is articulated to the almighty for lavishing the blessings and grace for the physical and mental health given to complete dissertation successfully.

The dissertation work was conducted with the assistance of many professional experts. The investigator is whole heartedly indebted to the research advisors for their comprehensive assistance in various forms.

I wish to express my gratitude to **Dr. V. Kanagasabai**, M.D, Dean, Madras Medical College, Government General Hospital- Chennai, for his encouragement to conduct the study.

It is my pleasure and privilege to express my deep sincere gratitude to **Dr. Mrs**. **M. Mohanambal**, M. D., DGO, Director, Institute of Obstetrics and Gynaecology and Hospital for Women and Children, for permitting me to the study.

It is my longest desire to express my gratitude and exclusive thanks to **Dr. R. Lakshmi** Msc., (N), Ph.D, Principal, College Of Nursing, Madras Medical college, Chennai. It is a matter of fact that without her esteemed suggestions, this work could have been not presented in the manner in which it has been made.

It's a pleasure to show my heartfelt gratitude to **Dr. K. Menaka**, Msc., (N), Ph.D, Reader, College of Nursing, Madras Medical College, for her valuable guidance.

It's my privilege and courage to extend my sincere gratitude to **Mrs**. **J. Alphonsa Maschrenas**, Msc (N), Lecturer, Department of Obstetric and Gynaecological Nursing, College of Nursing, Madras Medical College for her valuable guidance and thought provoking stimulation for my successful completion of dissertation.

I wish to express my sincere gratitude to **Mrs. R. Saroja**, Msc (N), Lecturer, Department of Obstetrics and Gynaecological Nursing, College Of Nursing, Madras Medical College, and **Dr. V. Kumari**, Msc., (N), Ph.D, Lecturer, Department of Obstetric and Gynaecological Nursing, College Of Nursing, Madras Medical, College, for their support and timely help, in spite of busy schedule, they continually motivated for successful completion of this dissertation.

I would like to express my special thanks to **Mrs. S. Rajeshwari**, Sri Ramachandra College Of Nursing, Chennai and **Mrs. I. Safreena**, M, S. A. J. College Of Nursing, Chennai for validated the contents of the tool for my study.

I wish to extend my gratitude and special thank to **Mr. A. Venkatesan**, Msc (Statistics), PGDCA, Lecturer in Statistics for his valuable guidance and helping the statistical analysis of the data, which is the core of the study.

I am thankful to the librarian **Mr. Ravi**, M.A., B.L., L. Sc, College Of Nursing, Madras Medical College who help me avail library facility.

I wish to extend my gratitude to **Mr. James Mano**, BA, for his valuable contribution in making grammatical correction of the study report.

Taking this opportunity, I would like to pen down the pride, of support and encouragement from my husband **Mr. P. Jaganathan**, throughout this study.

I extend my thanks to the pregnant mothers those who have participated in the study for their cooperation.

In conclusion, I could like to express my sincere thanks to those who have helped me to complete this study.

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ABSTRACT

Passing through the developmental tasks of pregnancy is natural as passing through the developmental tasks of any other life-changes, such as puberty. Psychological science of pregnancy is advancing rapidly; a major focus concerns stress process in pregnancy that cause preterm and low birth weight babies. The current evidence shows that pregnancy anxiety is key risk factor in the etiology of preterm and chronic stress and depression in the etiology of low birth weight. The statement of the problem was to assess the maternal psychosocial adaptation among high risk primi and multigravida mothers admitted in antenatal wards at Institute of Obstetrics and Gynecology at Chennai. Objectives of the study was to assess maternal psychosocial adaptation among high risk primigravida mothers to assess maternal psychosocial adaptation among high risk multigravida mothers, to compare maternal psychosocial adaptation between high risk primi and multigravida mothers and to associate the maternal psychosocial adaptation of high risk primi and multigravida mothers with selected demographic variables. The conceptual frame work adopted for this study was based on Betty Neuman's system model. According to the statement of problem and objectives to be achieved descriptive study design was adopted. Sample consisted of 100 high risk antenatal mothers at third trimester who attended Institute of Obstetrics and Gynaecology; data were collected using structured interview schedule and analyzed by descriptive and inferential statistics in terms of mean, standard deviation, chi-square test and student t test. Findings of the study revealed that high risk primi gravida had 48% of adequate level and 20% of inadequate level of psychosocial adaptation. Multigravida had adequate level of psychosocial adaptation 86%.On comparison high risk multigravida (86%) had better level of psychosocial adaptation than high risk primi gravida mothers (48%). The study revealed that there is significant association between age, educational status, family type and support system of high risk antenatal mothers with maternal psychosocial adaptation. Planned parenthood, antenatal counseling, involving psychological assessment in every antenatal visit play an important indicator in promoting psychosocial health of the mother thereby bringing effective perinatal outcome

CHAPTER I

INTRODUCTION

"Passing through the development of pregnancy is natural as passing through the development of any other life-changes, such as puberty".

Pregnancy for a first-time mother is "a period of transition between two lifestyles", that of a "woman-without-child" and that of a "woman-and-child". Transition between the two lifestyles can be viewed as a *paradigm shift*, the paradigm being understood here as a constellation of current self-image, beliefs, values, priorities, behavior patterns, relationships with others, and set of problem-solving skills.

The decision to become pregnant and the way in which a woman experiences and perceives the pregnancy is influenced by her present circumstances, age, education, health, relationship with others, current levels of stress and social setting. The initial reaction of women to the knowledge of their pregnancy is varied even for planned pregnancies. Reactions may be positive, negative or mixed. But the feelings of ambivalence or rejection are common among many women during the first trimester as they attempt to assimilate this new information (**Oakley**). Thereby adaptation depends on the response and support of the significant others in the women's life (**Leifer**).

The identification of motherhood role is a process that primi gravida and multi gravida both experience, but from different perspectives. The primi gravida is wondering, what kind of mother she should be; as well as struggling to formulate a motherhood role. The multigravida will develop a mother's role with her first child, but with each additional child she may re- examine her role and encompass her new baby.

The self adaptation of pregnancy is essential for women to focus on task of pregnancy. Body image, independence vs dependence and self esteem are three important areas relating to self that affect a pregnancy experience. Body image is a mental picture affected by experiences and perceptions.

The physiological appearance of a woman's body changes drastically, especially by third trimester, these results in negative feeling about her appearance and fear of damaging her body (**Arizmendi & Affonso**).

Wlokind and Zajicek stated that during pregnancy a woman's self esteem is related to the way in which she copes with the pregnancy. **Lederman** found that women with a strong sense of self were able to set reasonable expectations for labour as they knew how they would handle crisis due to their handling of such situations previously.

Women with positive body image, high self- esteem and one who is generally an independent person will adapt more easily to her pregnancy and cope more effectively with the changes than one who has low self esteem and negative body image.

Woman experiences many emotional changes during her pregnancy as a result of the increase in hormonal level and reaction to her changes in status from women to mother. The varying emotions are crying, insomnia, difficulty in concentrating as well as having a positive sense of well being. The emotional changes tend to mirror the physical changes and psychological issues of women experience during all three trimesters.

During third trimester the emotional reaction center on the ability and appearance of her body. A feeling of being overweight, less attractive, a decrease in sex interest, less tolerance level and wants the pregnancy to get over (**Lips**). The emotions reaction may increase when there is marital tension, stresses in life circumstances, difficulties in the pregnancy and conflicts around the pregnancy.

The literature indicates that couples with an egalitarian lifestyle were able to adapt to pregnancy and adjust their relationship to include a new family member and incorporate their new roles as mother and father into their relationship. **Lederman** stated marital bond to accept change; namely, the husband's concern for his wife's needs as an expectant mother like empathy, communication, sharing, cooperativeness and trustworthiness; the wife's concern for her husband's need as an expectant father; the

degree of closeness and conflict in their relationship and the husband's adjustment to his new role as father.

The socioeconomic situation is a important issue for women and their pregnancy. This is influenced by age, education, marital status, housing, career decisions and finances. **Yarrow** cited that women must deal with external factors during pregnancy like illness of her husband or death in the extended family, isolation from family supports, and relationship problems with parents.

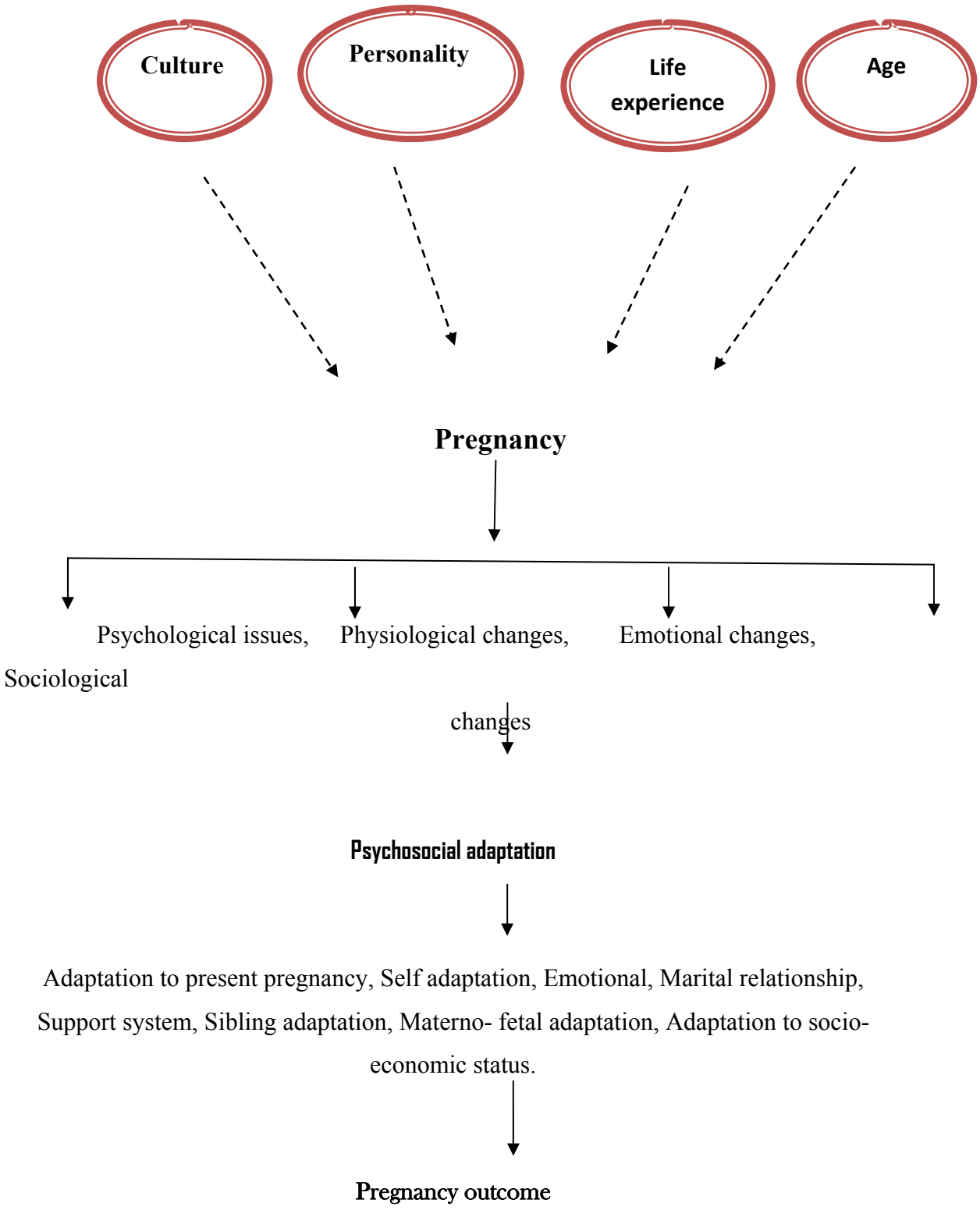
Throughout each trimester the fetus experiences certain developmental milestones as it prepares to become self- sustaining afterbirth. The development of the fetus is medically monitored throughout pregnancy; the result of the monitoring and how this information is presented may be a stress for many women.

There are many different theories concerning pregnancy and its psychological process. It has been viewed as a developmental process, a time of crisis and where growth is through crisis resolution (**Grossman et al**). On the other hand, the developmental process requiring adaptation and integration on the part of the women and her family (**Lederman**). This process depends on the physical change, psychological state of a woman, her social situation and her support system. All these factors help to determine her ability to adapt readily or with some difficulty in her state of pregnancy.

The factors affecting pregnancy is a complex process which includes her genetic makeup, cultural background, and life experience before pregnancy and her stages of personal developments at the time of conception and during pregnancy. Pregnancy is complicated by the interaction of all the components thus creating a very individualized experience for each woman's life time when she becomes pregnant.

Thus a pregnant woman's psychological health is a significant predictor in intrapartum, newborn and postpartum outcomes. Antenatal psychosocial problems may be associated with unfavorable postpartum outcomes.

Figure: 1 **MULTIDIMENSIONAL PROCESS OF PREGNANCY**



NEED FOR THE STUDY

"The relationship of maternal psychosocial adaptation in pregnancy to maternal anxiety and labor progress during childbirth."

Acceptance of pregnancy and her relationship with her mother play an important part in developing a philosophy of pregnancy- **Lederman**. During II trimester mood becomes introspective in an effort to adapt and there is a sense of dependency and need to be natural- Hassid. Ability to adapt to the marriage life situation will influence her response to her pregnancy experience- sheresherfsky (1983).

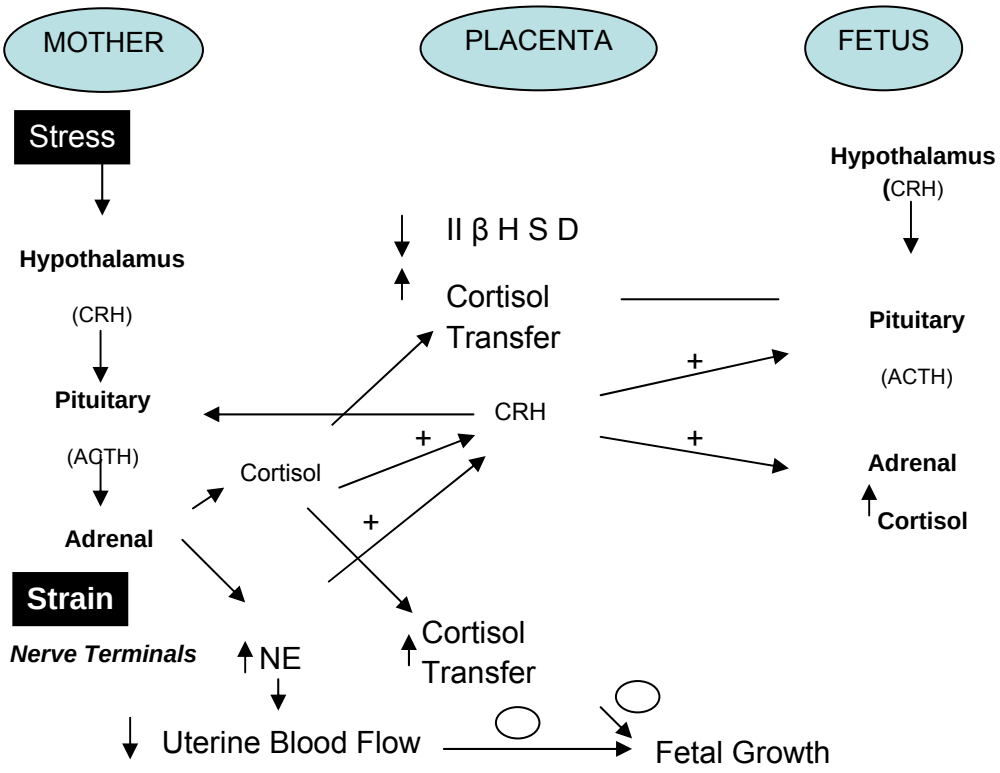
By third trimester women are aware of changing body image. They may wonder whether their body will ever be normal again. Physical activities become much more difficult due to enlarged abdomen. They also feel that they had enough and want the experience to be over, but do not want labour and delivery- **Brown and Rubin**. During this period the woman still experiences anxiety around thoughts of herself as mother and she will deal with new baby. By the end of third trimester the primi mother able to visualize herself as mother (Lederman 1994).

The domestic violence during pregnancy was associated with adverse clinical and psychological outcome for women. Multi gravida is difficult to accommodate the new child into the family requires that the women acceptance of the baby's other sibling. Both primi and multi gravida mothers focus on labour and birth during third trimester and wonder how they will cope with this experience. They may have fear regarding loss of control, helplessness, pain and loss of self esteem.

Research on the psychological changes in pregnancy indicates that this life changes event may provoke anxiety. This adaptation may have effect on fetus, increase in labour complication, affect pregnancy outcome- **Beck et al.**

Psychological science of pregnancy is advancing rapidly; a major focus concerns stress processes in pregnancy and cause preterm and low birth weight babies. The current evidence shows that pregnancy anxiety is key risk factor in the etiology of preterm and chronic stress and depression in the etiology of low birth weight.

Figure: 2 **MATERNAL-PLACENTAL–FETAL INTERACTION OF STRESS**



CRH:"The Coordinator of the Stress Response"

The above figure shows the maternal- placental- fetal interaction that play important functional roles during development. If maternal stress signals are excessive in early pregnancy, cortisol can cross the placenta and inhibit fetal pituitary function. Increased cortisol can also effect fetal growth. In addition excessive catecholamine production from the maternal adrenal can effect blood flow to the fetus and effect fetal growth. Meanwhile placental CRH from the placenta enters the fetal circulation and stimulated fetal adrenal production of dehydroepiandrosterone increasing estrogen production, important for initiating parturition.

Table: 1 STATISTICS OF HIGH RISK PREGNANT WOMEN ADMITTED AT INSTITUTE OF OBSTETRICS AND GYNAECOLOGY- AUGUST, 2011

SNO	HIGH RISK PREGNANCIES	FREQUENCY
1.	Placenta previa	30
2.	Gestational diabetic mellitus	60
3.	Pregnancy induced hypertension	65
4.	Anaemia complicating pregnancy	70
5.	Heart disease complicating pregnancy	10
6.	Rh incompatibility	10
7.	Pregnancies with previous caesarean section	28
8.	Twin gestation	5
9.	Elderly primigravida	18
10.	Hydramnios	68

Table: 2 STATISTICS OF ABNORMAL DELIVERIES AT INSTITUTE OF OBSTETRICS AND GYNAECOLOGY- AUGUST 2011.

SNO	ABNORMAL DELIVERIES	FREQUENCY
1.	Ventous assisted	40
2.	Forceps assisted	38
3.	Caesarean section.	455

Table: 3 STATISTICS OF PRETERM AND LOW BIRTH WEIGHT BABIES ADMITTED AT NICU, IOG- 2011.

SNO	PRETERM AND LOW BIRTH WEIGHT	FREQUENCY
1.	Preterm babies got admitted in NICU	1523
2.	Low birth weight babies	988
3.	Very low birth weight babies	408

The health professionals who work with pregnant women need to have an understanding of possible stressors that affect the psychosocial aspect during prenatal period, because they were in position to provide means of support to the antenatal mothers. It will also provide more information to women thereby increase their knowledge in the process of pregnancy- physical, psychological, sociological, emotional aspects. During clinical posting in antenatal wards, the research candidate has came across the stress and anxiety that the high risk pregnant women are undergoing, hence the research candidate decided to assess the maternal psychosocial adaptation among high risk pregnant women.

PROBLEM STATEMENT

Assess maternal psychosocial adaptation among high risk primi and multigravida mothers admitted in antenatal wards at Institute of Obstetrics and Gynecology, Chennai- 08.

OBJECTIVES:

1. To assess maternal psychosocial adaptation among high risk primigravida mothers.

2. To assess maternal psychosocial adaptation among high risk multigravida mothers.

3. To compare maternal psychosocial adaptation between high risk primi and multigravida mothers.
4. To associate the maternal psychosocial adaptation of high risk primi and multigravida mothers with selected demographic variables.

HYPOTHESIS

There is a significant difference in maternal psychosocial adaptation among high risk primi and multigravida mothers.

OPERATIONAL DEFINITION:

Adaptation: The ability of the primi and multi gravida mother has ability to adjust to present pregnancy

Maternal psychosocial adaptation: Mother involving or relating to both social and psychological aspect of present pregnancy by the primi and multigravida mothers.

Pregnant women: carrying offspring within body during 3rd trimester irrespective of gravidity.

Gravidity: the status of women regarding total number of pregnancy including the current one.

High risk primigravida: A great chance of danger for women being pregnant for first time during her life.

High risk multigravida: A great chance of danger for women who has been pregnant more than once.

ASSUMPTION

High risk primigravida mothers will have difficulty in psychosocial adaptation during present pregnancy.

High risk multigravida mothers will have some difficult in psychosocial adaptation during present pregnancy.

DELIMITATION

The study was conducted for 4 weeks from 29.08.2011 to 29.09.2011at Institute Of Obstetrics And Gynaecology, Chennai- 08.

CHAPTER II

REVIEW OF LITERATURE

The review of literature entails systematic location, scrutiny and summary of written material that contains information relevant to the study. An extensive review of literature relevant to the research topic was done to gain insight and collect maximum information for laying foundations for the study.

PART I: Review of literature

PART II: Conceptual framework

Review of literature is organized under following headings;

1. Literature related to maternal psychosocial adaptation
2. Literature related to maternal anxiety during pregnancy
3. Literature related to maternal distress during pregnancy
4. Literature related to support system during pregnancy
5. Literature related to domestic violence during pregnancy and its outcome

PART- I

1. Literature related to maternal psychosocial adaptation

Lin CT, Chou FH, in 2011, conducted a cross-sectional and comparative study to examine women's psychosocial adaptation during different trimesters of pregnancy and to compare maternal psychosocial adaptation between primi gravida and

multigravida. A convenience sample consisting of 369 primigravida and 348 multigravida was taken. A Demographic Inventory and the Chinese version of the Prenatal Self-Evaluation Questionnaire (PSEQ) were used to collect data.

Results showed significant differences between the two sample groups in terms of PSEQ total scores and scores for "concern for well-being of self and baby," "preparation for labor," and "fear of helplessness, and loss of control in labor." This indicated that primigravida had poorer maternal psychosocial adaptation than multigravida.

A descriptive study was conducted by **Lederman RP,** in 2011 to assess psychosocial assessment in prevention of preterm birth. Author stated that there is a significant role for nurses in assessment and intervention based on their education in pregnancy. Pregnancy-specific anxiety, assessment and intervention methods that include the father/partner and couple using family system methodologies were used. Variations in anxiety are discussed in terms of implications for maternal/paternal fetal and child attachment from birth to adulthood. There is a significant impact for parent-child mental and physical health, and the need for development of long-term interventions that include parental coping strategies and parental empowerment.

Miller T, in 2011 conducted qualitative, longitudinal study to assess first time becoming mother signals major life transition. Author reveals a gap between the women's expectations and their unfolding mothering experiences. The unexpected hard work and exhaustion of caring for a new baby can leave women confused and ambivalent about their early mothering experiences. These findings have implications that how antenatal preparation and postnatal care are planned and delivered.

Bayrampour H, Heaman M, in 2011 conducted comparative study to assess demographic and obstetric characteristics of Canadian primiparas women of advanced maternal age with those aged 20 to 29 yrs and 30 to > 35 yrs. The sample included 301 primiparas women in which data collected through the national Maternity

Experiences Survey (MES) of the Canadian Perinatal Surveillance System. T Estimates were calculated using sample weights of the survey.

There were no significant differences in rates of preterm birth, low birth weight, and small-for-gestational age infants. The study concludes that pregnant women of AMA differ from younger women in demographic characteristics, knowledge level, and some health behaviors and pregnancy outcomes.

Gameiro S, Canavarro MC, in 2011, conducted study to assess parental investment in couples who conceived spontaneously or with assisted reproductive technique. A total of 39 couples who conceived with ART and 34 couples who conceived spontaneously completed self-report questionnaires about depression, marital satisfaction and social support at their 24th pregnancy week and about PIC 4 months after the partum. Data were analyzed with multilevel regression analyses. There was a strong association between spouses on parental investment and investment was associated with couples' satisfaction with their marital relationship and the amount of support they perceived from their network.

Nilsson C et al, in 2008 conducted descriptive phenomenological study to describe previous experiences of childbirth in pregnant women. Nine women with intense fear of childbirth who were pregnant with their second child and considered their previous birth experiences as negative. Interviews that were transcribed verbatim and analyzed with a reflective life-world approach. The result showed that the experience remained etched in the women's minds and gave rise to feelings of fear, loneliness, and lack of faith in their ability to give birth and diminished trust in maternity care. Thus authors concluded that previous childbirth experiences for pregnant women with intense fear of childbirth have a deep influence and can be related to suffering and birth trauma.

Gameiro S, in 2008 conducted study to examine the psychosocial adjustment of 35 Portuguese couples who conceived through Assisted Reproductive Technologies (ART) and 31 couples with a spontaneous conception during their

transition to parenthood (pregnancy and 4 months postpartum). Couples completed self-report questionnaires regarding their perceptions of pregnancy and parenthood, psychological distress, quality of life, marital relationship, and parenting stress.

Compared with parents who conceived spontaneously, The result shows that parents who conceived through ART perceived pregnancy as being more risky and demanding, reported a decrease in their psychological quality of life, and ART fathers only perceived themselves as being more competent than fathers who conceived spontaneously.

Chou WJ, in 2007conducted study to evaluate the psychological status and adjustment of the foreign-born mothers in Taiwan, and assess the influence of their immigrant motherhood on child development. The sample consists of 94 immigrant mothers (41 Chinese, 37 Vietnamese, and 16 Southeast Asian women) and their 104 children. Information was obtained by a clinical interview for medical history and sociodemographics, five standardized self-administered questionnaires for maternal general mental health, maternal depression, maternal cognitive functioning, home environment, and child development. The result shows that Chinese mothers were significantly more educated and less likely to marry via referral agencies than mothers from Vietnam and other countries in Southeast Asia. Immigrant mothers had high rates of psychological distress (70%) and marked depression (24%). Chinese mothers had the highest degree of cognitive functioning and provided a better home environment for their children. Thus; this study highlights the need to give continuous psychosocial support to immigrant mothers and to identify early developmental delays among their children.

Wei .W, in 2007conducted study to investigate effects of an integrated intervention on psychosocial competence after abortion in unmarried adolescent pregnancies. Population consists of 385 unmarried adolescent pregnancies aged 15 to 24 years (75.1% employed, 24.9% students) were recruited in the study, of which 190 were allocated into the experimental group and the rests as controls. The Rosenberg Self-esteem Scale (SES), the shortened version of Tyler's Behavioral Attributes of Psychosocial Competence Scale-Condensed Form and the Nowicki-Stricland.

Questionnaires were simultaneously administered with abortion service and two-months after intervention.

Results showed noticeable changes in coping style and LOC in the experimental group, except for self-esteem ability when comparing with the controls. Thus authors concluded that the psychosocial competence was significantly improved after receiving the intervention.

Serçekuş P, conducted quasi-experimental study to assess the effects of antenatal education on prenatal and postpartum adaptation in Turkish. A Roy Adaptation Model-based study with 120 nulliparous women was conducted between 2006 and 2008. Data were collected using a demographical data form and Lederman's prenatal and postpartum self-evaluation questionnaires. The findings shows that there are statistically significant differences between the groups in terms of prenatal adaptation, no difference was found in postpartum adaptation. Post hoc analysis showed that women in the experimental groups (individual and group education) were better adapted in the prenatal period compared with those in the control group.

Chalners et al in 1999, conducted larger study of 782 subjects attempted to explain obstetric difficulties on the basis of psychosocial conditions which exist during pregnancy. Multivariate statistics technique were employed to analyses the numerous variables measure. Results suggested that age at birth of first child, educational level, menstrual history, attitude to pregnancy and age at menstruation best predict obstetric difficulties.

2. Literature related to maternal anxiety during pregnancy

Lukasse .M et al., 2010, conducted cross sectional study to examine the association between a self-reported history of childhood abuse and fear of childbirth. Sample consists of 2,365 pregnant women. Data was collected with Norvold Abuse Questionnaire and Wijma Delivery Expectancy Questionnaire. The results showed that all women, 566 (23.9%) had experienced any childhood abuse, 257 (10.9%) had experienced emotional abuse, 260 (11%) physical abuse, and 290 (12.3%) sexual abuse.

Women with a history of childhood abuse reported severe fear of childbirth significantly more often than those without a history of childhood abuse ($p = 0.001$).

Thus authors concluded that a history of childhood abuse significantly increased the risk of experiencing severe fear of childbirth among primiparas. Fear of childbirth among multiparas was most strongly associated with a negative birth experience.

Pond EF, Kemp VH, in 2005 conducted comparative study to investigate anxiety and self-confidence in adolescent and adult pregnant women. A convenience sample consist of 35 adolescents in ages 13 to 16, and 58 adult women in ages 21 to 33, participated in this study. Spielberger's State-Trait Anxiety Inventory (STAI) and Pharis Self-Confidence Scale were administered during the women's second trimester of pregnancy. Data were analyzed with Pearson correlation coefficients and t-tests. A significant negative correlation was found ($r = -.17$, $p = .05$ in each case). Thus study shows higher the anxiety level, the lower the self-confidence.

T. Austin MP, Colton J, in 2004, conducted study to assess the value of the Antenatal Risk Questionnaire (ANRQ) as a predictor of postnatal depression, to evaluate its acceptability to pregnant women and midwives. The sample of 1196 women administered Pregnancy Risk Questionnaire at 2 or 4 months postpartum to assess for major depression (N=276). The most 'clinically' useful cut off on the ANRQ was a score of 23 or more, yielding a sensitivity of 0.62 and specificity of 0.64 with positive predictive value of 0.3. Thus investigators conclude that the ANRQ is a highly acceptable self-report psychosocial assessment tool which aids in the prediction of women who go on to develop postnatal depression.

Ip al, in 2000 at Hong Kong conducted study to assess anxiety, pain, dosage of pain relieving drug used and length of labour among 45 primi gravid women had attended antenatal classes and their partner present during labour. State- anxiety inventory, visual analogue scale was used. The result shows that there were no significant association between level of emotional support and maternal outcome measures, but

perceived practical support was positively related to the dosage of pain relieving drug used and total length of labour.

3. Literature related to maternal distress during pregnancy

Dunkel Schetter C, et al in 2011, conducted study to assess the stress processes in pregnancy and effects on preterm birth and low birth weight. Author stated that pregnancy anxiety is a key risk factor in the etiology of preterm birth, and chronic stress and depression in the etiology of low birth weight. Evidence regarding social support and birth weight is also reviewed with attention to research gaps regarding mechanisms, partner relationships, and cultural influences. The neurodevelopment consequences of prenatal stress are highlighted, and resilience resources among pregnant women are conceptualized. Finally, a multilevel theoretical approach for the study of pregnancy anxiety and preterm birth is presented to stimulate future research.

Song JE, et al 2010, conducted longitudinal descriptive study to compare levels of postpartum fatigue, depression, childcare stress, and maternal identity according to postpartum period between primiparas who used Sanhujori facilities and those who did not. Participants were 55 healthy primiparas; 21 using Sanhujori facilities and 34 not using these facilities during the first three weeks after childbirth. Data were collected from October 2008 to April 2009 at three measurement points, 2-4 days after childbirth (T1), 4-6 weeks (T2), and 12-14 weeks (T3). Data were analyzed using the SPSS 17.0 WIN program. There was a significant difference in childcare stress between the two groups at 4-6 weeks after childbirth. The author reported that postpartum depression and childcare stress at 4-6 weeks were significantly higher than those of the other postpartum periods, while maternal identity was significantly lower.

Kaaya SF et al., in 2010 conducted descriptive study to describe the sources and characteristics of distress during pregnancy, and idioms of distress that could inform cultural adaptation of depression screening tool. Data were collected using unstructured interviews from 12 traditional practitioners and 10 peri-urban women with

previous pregnancy related mental health concerns identified using depression vignette and narrative analysis was used.

Thus experiences of psychological distress showed distinct local idioms that clustered in patterns similar to symptoms of biomedical depressive episodes. In 2010, **Emmanuel E, et al** conducted study to analysis the concept of maternal distress. Data sources are collected from the SCOPUS, CINAHL and Medline databases were searched for the period from 1995 to 2009 using the keywords. Steps from Rodgers' evolutionary concept analysis guided the conduct of this concept analysis. The results shows that four attributes of maternal distress were identified as responses to the transition to motherhood: stress, adapting, functioning and control, and connecting. Antecedents to maternal distress include becoming a mother, role changes, body changes and functioning, increased demands and challenges, losses and gains, birth experiences, and changes to relationships and social context. The extent of the impact depends on the level of maternal distress. Thus authors conclude that maternal distress offers a comprehensive approach to understanding maternal emotional health during the transition to motherhood.

Singer LT et al., in 2005 conducted prospective cohort study to determine longitudinal outcomes and contributors to parental stress and coping in mothers of very low-birth-weight (VLBW) children. Sample consists of VLBW children (n = 113), low-risk VLBW children (n = 80), and term children (n = 122) and their mothers from birth to 3 years. The result shows that after VLBW birth, Mother of high-risk VLBW children felt more personal stress (P = .006) and family stress (P = .009) under conditions of low social support. Thus authors concluded that parenting a VLBW child had both positive and negative outcomes, dependent on child medical risk, child IQ, social support, and maternal coping mechanisms, suggesting that mothers experience posttraumatic growth and resilience after significant distress post partum.

In 2002 a prospective study was conducted by **Villar et al**, in Canada regarding influence of maternal stress, social support and life styles over the course of pregnancy. 102 women in third trimester were included on monthly basis. Hassles stress

scale, state anxiety state and pregnancy specific stress was taken monthly. One month following delivery, a telephone interview also conducted.

Result shows that 63% of women experienced pregnancy complication reported high level of state anxiety during hassles and pregnancy specific stress. The result indicates that certain psychosocial and life style variables may be differentially associated with complication accordingly at various phases of pregnancy.

4. Literature related to support system during pregnancy

Lagerberg D et al., 2011, conducted a cross-sectional questionnaire study to explore neighbourhood-level differences in health behavior, maternal stress and sense of coherence, birth weight, child health and behavior. 2006 pairs of Swedish mothers and children, aged approximately 20 months, from the general population participated in the study. Data were collected in 2002-2003 and 2004-2005 through the Child Health Services. They felt less stress from social isolation and had a higher sense of coherence. Thus investigators felt that previous knowledge by showing that Status-based geographic differences in parenting and health parameters can be non-significant in an equitable society

Senturk V, Abas M et al., in 2011 conducted cross-sectional survey study to assess social support: particularly the quality of the marital and family environment. The investigators selected convenience samples consist of 772 women. Edinburgh Postnatal Depression Scale (EPDS) and Close Person Questionnaire with respect to the husband, mother and mother-in-law. The result shows that prevalence of case-level depression was 33.1% and this was associated with lower social support from all three family members but not with traditional/nuclear family structure. Thus investigators specify that Lower quality of relationships between key family members was strongly associated with third trimester depression.

Reich SK et al., in 2010, conducted study to examine nursing's contribution to understanding the parent-adolescent and the teen parent-child relationships. The shows the relationships between parents and adolescents may reflect

turmoil and affect adolescents' health and development. The social and developmental contexts for teen parenting are powerful and may need strengthening.

Nurse researchers have begun to provide evidence for practitioners to use in caring for families of adolescents and teen parents to acquire interaction skills that, in turn, may promote optimal health and development of the child.

Kennell et al., in 2008 conducted randomized trial of the provision of psychosocial support to high risk women in America who were 15 to 22 weeks of gestation during prenatal care were randomly assigned to treatment group. The intervention group (N= 1115) received four home visit and health education also provided. The control group (N= 1120) received routine care. The result shows that there is significant difference in low birth weight of preterm outcome between intervention and control group.

Klermann et al., in 2008 conducted randomized trial of augmented prenatal care, including social support among low income African American pregnant women in Albama. Sample consists of 318 antenatal mothers less than 26 weeks of gestation with no medical complication and high risk in present pregnancy. Results shows that women I intervention group were more likely than women in comparison group to report smoking cessation and grater satisfaction with prenatal care.

Leal C et al., in 2006 conducted follow- up study to investigate the relationship between social capital and social support and the adequate use of prenatal care. Sample consists of 1,485 pregnant women during the first trimester in two cities. Hierarchized multinomial logistic regression was used in the statistical analysis. Result shows that adequate prenatal care was associated with high social capital and inadequate prenatal care with lower social capital. Contextual social capital and social support were found to be social determinants for the appropriate use of prenatal care.

Hildingson I., in 2004 conducted cross sectional study to describe and study background characteristics, feelings and support in relation to thoughts about

childbirth in mid-pregnancy, in women and their partners and to analyze which factors are most important for having thoughts and feelings about childbirth.

1212 women and 1105 men collected and analyzed using relative risks with 95% confidence interval and logistic regression. Study result showed that a high proportion of women (75%) and men (67%) reported having thoughts about childbirth. In women childbirth related fear Odds Ratio (OR) 2.7; high level of education (OR) 1.8, and major emotional changes (1.5), were the most important factors associated with having thoughts about childbirth. In men, high level of education getting the opportunity to ask question at prenatal visits OR 1.6 [95% CI 1.17-2.07], and expecting the first baby OR 1.6 [1.17-2.07] contributed most to the model. This study shows that the majority of prospective parents think about the birth of their baby in mid-pregnancy. But women's thoughts are more based on emotional and physical changes and fears while men's are more based on the social situation such as expecting the first baby and organizational issues in prenatal care, and instrumental issues such as finances.

Feldman et al., in 2000 conducted a prospective observational study in maternal social support during pregnancy among 247 women in prenatal care at North America. Complete interview about support from their family and father of the baby was collected by interpersonal social support. Result shows that social support was associated with birth weight.

Alio AP et al., in 2000, conducted study on efforts to reduce infant mortality in the United States has failed to incorporate paternal involvement. Research suggests that paternal involvement, which has been recognized as contributing to child development and health for many decades, is likely to affect infant mortality through the mother's well-being, primarily her access to resources and support. Thus authors view that equitable paternity leave, elimination of marriage as a tax and public assistance penalty, integration of fatherhood initiatives in MCH programs, support of low-income fathers through employment training, father inclusion in family planning services, and expansion of birth data collection to include father information.

Norbeck et al., in 2000 at San Francisco conducted study among 208 low income medically normal women to measure life stress, social support and anxiety state at mid and late pregnancy. Outcome variables like pregnancy complications, birth weight and gestational age included. The result shows that high social support was significant in according for pregnancy outcome indicates that the social network reinforce negative health practice.

5. Literature related to domestic violence during pregnancy and its outcome

Shay-Zapien G, in 2010 conducted study to examine the impact of abuse on women, fetus, and developing children. Despite the research in this area, the full impact of abuse on the long-term physical and psychosocial well-being of women and their families is not fully understood. Intimate partner violence during pregnancy has an impact on not only the woman but the developing fetus and the extended family. It is essential that all women be screened for intimate partner violence, and that nurses understand interventions that have been shown to be effective for this group of patients.

Audi CA, et al, in 2000 conducted cross-sectional study in Brazil to examine the association between domestic violence (psychological violence and physical or sexual violence) and health problems self-reported by pregnant women. Sample consists of 1,379 pregnant women attending prenatal care. Univariate analyses were used to estimate prevalence and unadjusted odd ratios. Multivariate logistic regression was used to identify the independent association between psychological violence and physical or sexual violence during pregnancy and women's health outcomes. Psychological violence and physical or sexual violence were reported by 19.1% and 6.5% of the pregnant women, respectively. Thus investigators concluded that well-organized health-care system and trained health professionals, as well as multisectorial social support, are necessary to prevent or address the negative influence of domestic violence on women's health.

CONCEPTUAL FRAMEWORK

Conceptual framework is interrelated concepts on abstractions that are assembled together in some rationale scheme by virtue of their relevance to a common scheme.

Group of concept, set of preposition that spells out relation between them. To overall purpose is to make scientific findings more meaningful and genralisable.

Betty Neuman's system model has been selected as the conceptual framework for this study which is relevant to the study in order to provide pregnant women to adapt in psychosocial aspect.

Neuman's (1982) model focuses on stress and stress reduction and is primarily concerned with the effect of stress on health. According to Neumann model view the person as an individual. She considers the client to be an open system interacting with the environment. The person has a core consisting of basic structure, surrounding the basic core structure are the concentric circles which include line of resistance and line of defense.In this study the person is the pregnant women. The basic core structure is adequate knowledge towards conception care

Line of resistance/ flexible line of resistance

These are the series of line surrounding the basic core structure. It represents the internal factors of a person that help to defend against stressor.The flexible line of resistance in this study is the perceived awareness of psychosocial adaptation.

Normal line of defense

It is solid line out of the lines of resistance. It refers to the equilibrium state or the adaptation state that the client has developed over a time.The normal line of defense in this study is the normal psychological status of the pregnant women.

Flexible line of defense

It is broken line outside the normal line of defense. It acts as a protective barrier to prevent stressor from breaking through the normal line of defense.In this study flexible line of defense is the cultural belief regarding psychosocial adaptation.

Stressors:

These are the stimulus that alters the system stability. The stressors in this study are lack of mental preparation, lack of stress reduction, low socioeconomic status, lack of support system that leads to abnormal pregnancy outcome such as preterm labour, preterm and low birth weight babies, IUGR.

Reaction to stressors

The reaction occurs when the flexible line of defense cannot protect a person from stressors.Reaction occurs to pregnant women when they are unaware about presence of anxiety and depression.

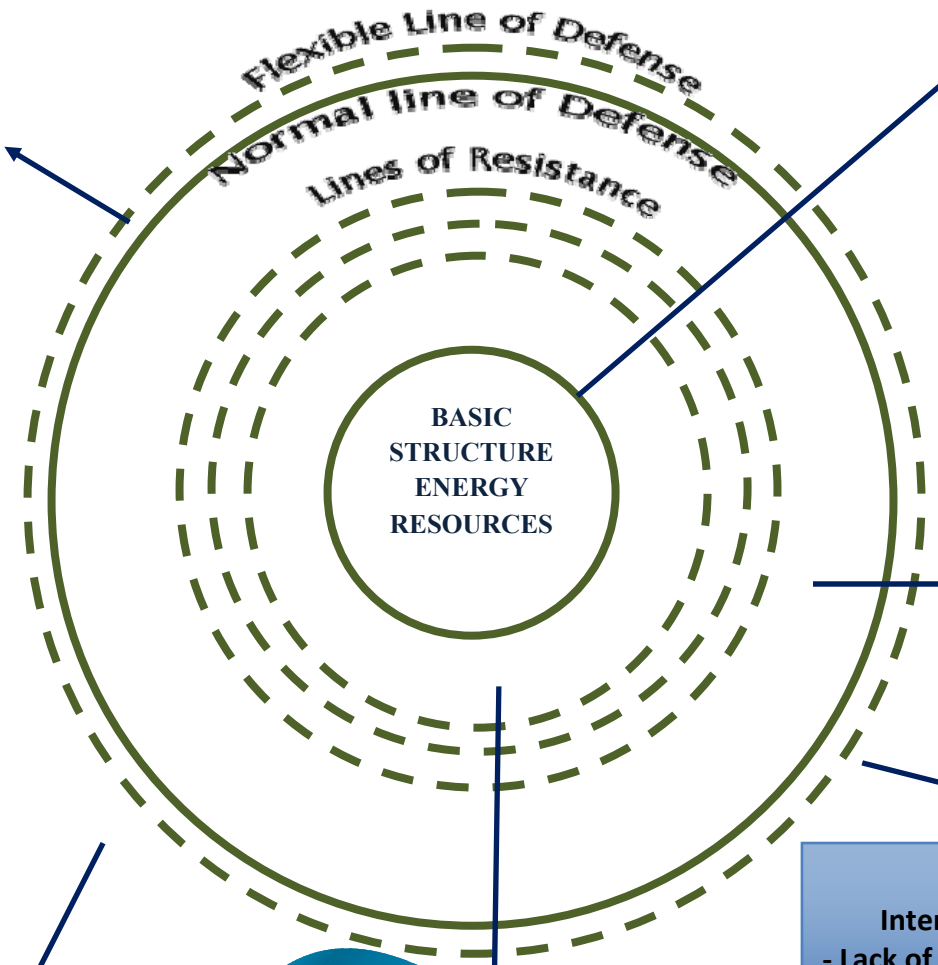
Reconstitution

It includes module to create awareness on coping with psychosocial adaptation in primi gravida mothers in order to minimize abnormal deliveries, bring out mother and baby healthy following delivery.Intervention is only primary prevention.

Figure: 2 MODIFIED BETTY NEUMAN'S SYSTEM MODEL

Primary prevention

- Stress reduction
- Mental preparation
- Diet modification
- Paternal involvement
- Maintains emotional stability
- Acceptance of pregnancy
- Self adaptation
- Adaptation to socio economic status.



Basic structure common to all

- Age
- Education
- Type of family
- Marital status
- Religion
- Family support

Degree of reaction

Antenatal: anxiety, depression

Intranatal: abnormal deliveries

Postnatal: preterm, LBW, Postpartum psychosis.

Stressors

Internal	External
- Lack of mental Preparation	- Negative life events
-Lack of conception Care	- lack of educational status
-Lack of stress Reduction	- low economic status
-Non- accept of Present pregnancy	- lack of support person

Module on coping with psychosocial adaptation for primi gravida mothers

CHAPTER III

RESEARCH METHODOLOGY

Research methodology is the systematic procedure involved in the study to develop or refine the methods of obtaining, organizing, analyzing and interpreting the data.

RESEARCH APPROACH

The approach adopted for the study is Quantitative Non- experimental approach.

RESEARCH DESIGN

The study design adopted is descriptive in nature.

STUDY SETTING

The study was conducted in antenatal wards at Institute of Obstetrics and Gynecology, Chennai. This esteemed institution was unveiled on 26th July 1844 for public service. It is a 752 bedded hospital caring for women & children and in that 62 beds in the antenatal wards no: 20 and 21. An average of about 62 to 64 inpatient high risk pregnant mothers were under expectant management.

POPULATION

The target population is high risk pregnant mothers who are in third trimester between 28 and 40 weeks of gestation got admitted in antenatal wards at Institute Of Obstetrics and Gynecology, Hospital for Women and Children.

SAMPLE

In this study, the sample consists of high risk primi and multigravida mothers who are in 3rd trimester between 28 to 40 weeks of gestation, who fulfill inclusion criteria.

SAMPLE SIZE

Sample size is 100: 50 primi and 50 multigravida mothers

SAMPLE TECHIQUE

Simple random technique by lottery method was used

CRITERIA FOR SAMPLE SELECTION

Inclusion –

1. Pregnant women who are at 3rd trimester between 28 to 40 weeks of gestation
2. High risk pregnant mothers;
   - Present obstetric complication like placenta previa, gestational diabetic mellitus, Pregnancy induced hypertension, short stature, previous LSCS, anemia, twin gestation, RH- ve, cervical incompetence, elderly primi, poly/ oligohydramnoius.
   - Past medical complication like heart disease complicating pregnancy, thyroid complicating pregnancy
3. Women who understands and speak Tamil

Exclusion_

1. Pregnant women in 1st and 2nd trimester
2. Multiparty and grand multigravida mothers.
3. Pregnant women who are in labour pain
4. Adolescent pregnant women
5. Unmarried pregnant women
6. Women who are not willing to participate

DEVELOPMENT AND DESCRIPTION OF TOOL

The instrument was developed by the investigator with the modification of Antenatal Psychosocial health assessment (ALPHA). This modified structured assessment form was developed with experts opinion and review of literature. Structured interview schedule was used to collect General Information, Obstetrics Information and Modified Antenatal Psychosocial Health Assessment.

SECTION A- Structured interview schedule was used to collect the general information like age, educational qualification, religion, employment status, type of family, social support

SECTION B- Structured interview schedule was used to collect the obstetrical data like gestational age, number of pregnancy, first antenatal visit, registration of pregnancy, presence of morning sickness, presence of health history. As these data gives demographic variables to assess maternal psycho social adaptation among pregnant

SECTION C- Structured interview schedule in form of Rating Scale was used to assess the maternal psycho social adaptation. The questions have been organized under the following heading;

-Adaptation to Present Pregnancy

- Self Adaptation

- Emotional Adaptation

- Marital relationship

- Social support

- Sibling adaptation

- Maternal fetal adaptation

- Socio economic adaptation

Scoring technique:

Minimum score: 52 maximum score: 158

- Not adapted: <52
- Moderately adapted: 53 - 105
- Adequately adapted: 106 – 158

CONTENT VALIDITY

Modified tool was used from standardized Antenatal Psychosocial Health Assessment –ALPHA. Content validity was obtained from two medical, two nursing experts and one statistical expert. Expert suggestions were incorporated in modification of tool.

RELIABILITY

The reliability of the tool was assessed by using Test Retest method and its correlation coefficient value is 0.81. This correlation coefficient is very high and it is good tool for assessing antenatal psychosocial adaptation.

EITHICAL CONSIDERATION

The investigator presented the research proposal to the institutional ethical committee at Madras Medical College and got approved to conduct the main study.

PILOT STUDY

A formal permission has been obtained from the Director, Institute of Obstetrics and Gyaecology, Egmore, Chennai- 8. The pilot study was done from 21.3.2011 to 27.3.2011 with ten samples using randomized sampling technique by lottery method. Analysis of the finding showed high consistency and feasibility of the study and after which the plan for actual study was instituted. The participants in pilot study were not included in the main study.

DATA COLLECTION PROCEDURE

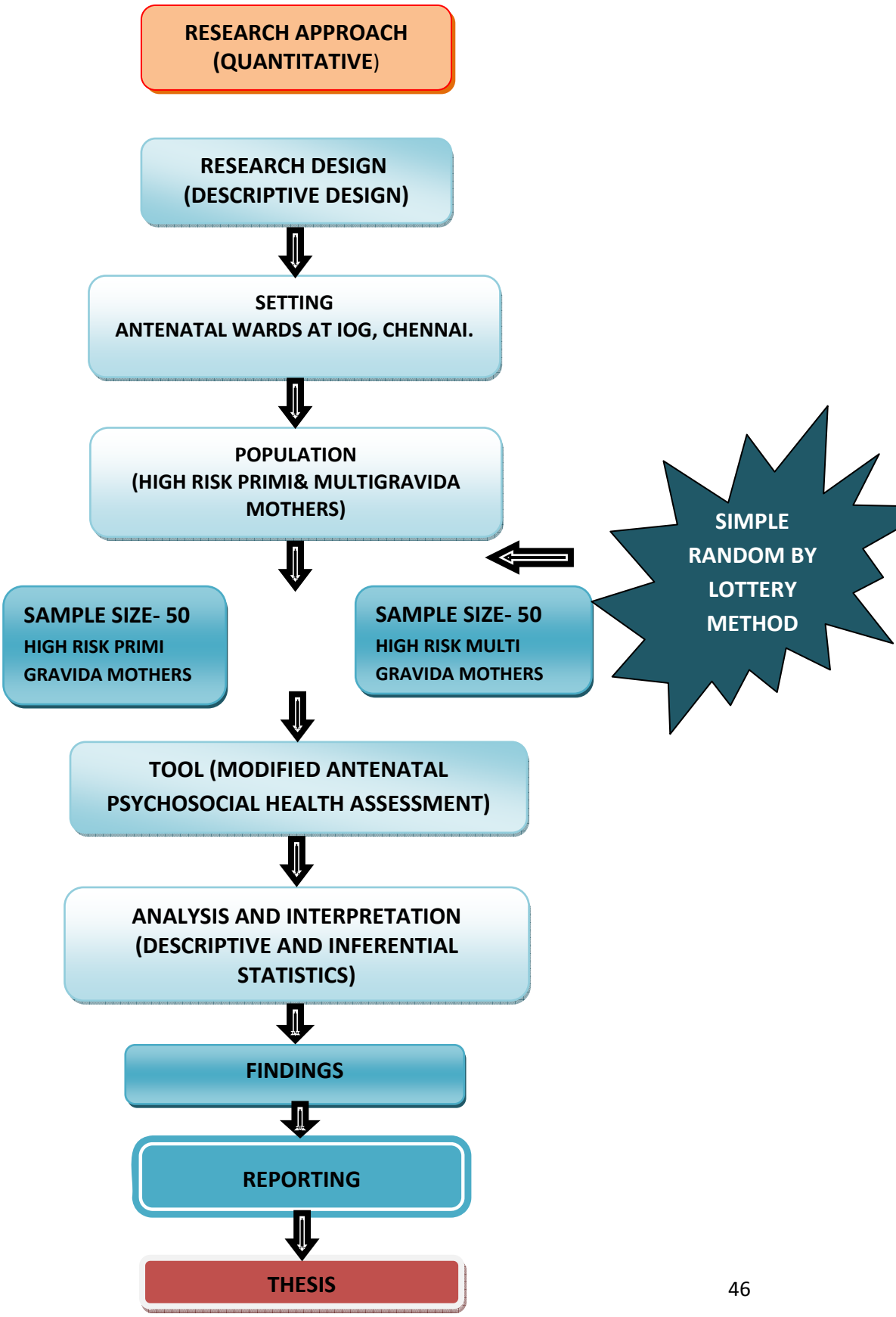
A written permission was obtained from the Director, Institute of Obstetrics and Gynaecology for conduction the study. The study was conducted from 29. 8.2011 to 29.9.2011. As described in the sample selection procedure, random sampling technique was used to select the sample from antenatal wards. The sample was selected as per the inclusion criteria. A brief introduction about the study were given to the pregnant women and assured that the data collected would be kept confidential.

The investigator initially established rapport and the purpose of the interview was explained and written consent was obtained. Every participant was interviewed for 15 to 20 minutes from 8.00 am to 1.oo pm. The investigator ensured the privacy, dignity, religious, and cultural belief of the individual were respected during the interview process.

PLAN FOR DATA ANALYSIS

Descriptive statistical methods like mean, median, standard deviation were used to analysis the demographic data. Chi square test and Karl Pearson co- relation method were used to analysis the association between psychosocial adaptation and number of pregnancy, weeks of gestation, presence of obstetrics complication, and presence of minor disorder.

Figure: 3 **SCHEMATIC REPRESENTATION OF THE STUDY**



CHAPTER IV

ANALYSIS AND INTERPRETATION

The data themselves do not provide with answer to the researcher question, that the data must be processed and analyzed in some orderly fashion. The data obtained were analyzed by descriptive statistical methods like mean, median, standard deviation and inferential statistical methods like Pearson Chi- square test and Student t test. The data collected were tabulated, analyzed and presented in tables. The findings were presented under the following heading;

SECTION- A: Distribution of demographic characteristic of antenatal mothers with frequency and percentage.

PART I: Distribution of demographic data of high risk antenatal mothers.

PART II: Distribution of obstetric information of high risk antenatal mothers.

SECTION -B: **Distribution of maternal psychosocial adaptation among high risk primi gravida mothers.**

PART I: Distribution of maternal psychosocial adaptation factors of high risk primigravida mothers.

PART II: Distribution of overall maternal psychosocial adaptation of high risk primigravida mothers.

SECTION- C: Distribution of maternal psychosocial adaptation among high risk multigravida mothers.

PART I: Distribution of maternal psychosocial adaptation factors of high risk multigravida mothers.

PART II: Distribution of overall maternal psychosocial adaptation of high risk multigravida mothers.

SECTION- D: Comparison of maternal psychosocial adaptation among high risk primi and multigravida mothers.

SECTION- E: Association of maternal psychosocial adaptation of high risk primi and multi gravida mothers with selected demographic variables.

PART I: Association between level of adaptation and their demographic variables of high risk primigravida mothers.

PART II: Association between level of adaptation and their demographic variables of high risk multigravida mothers.

SECTION A

DISTRIBUTION OF DEMOGRAPHIC CHARACTERISTICS OF HIGH RISK ANTENATAL MOTHERS

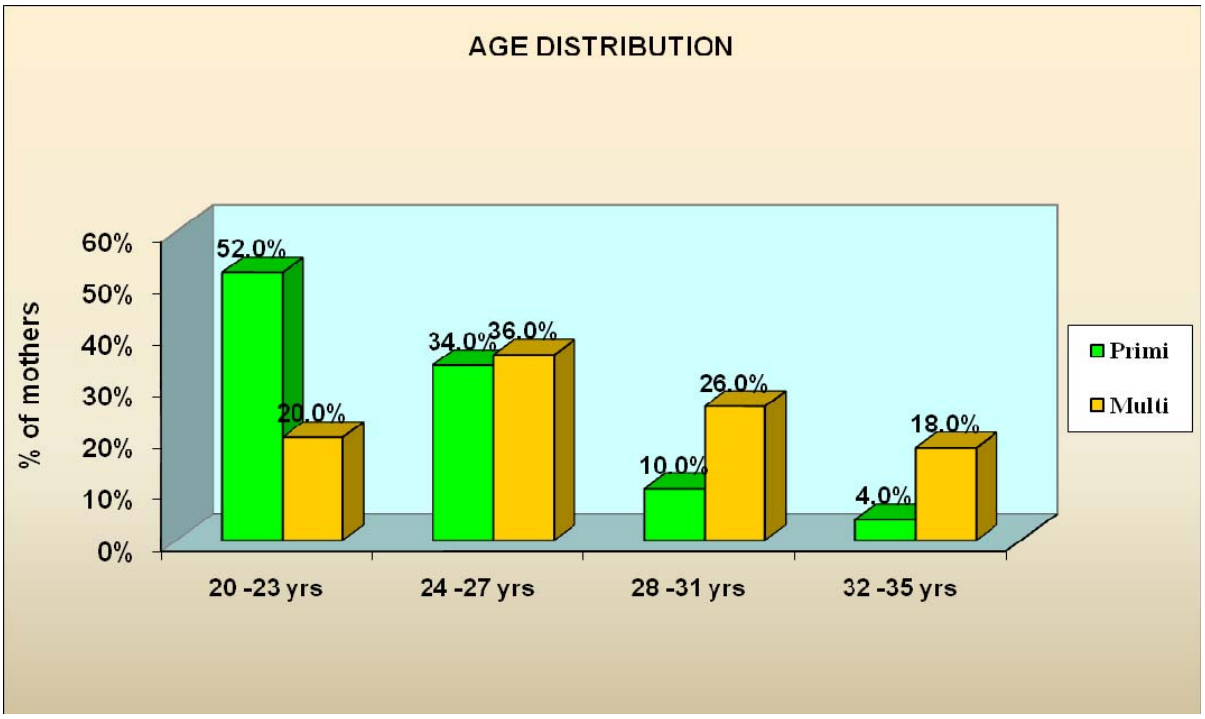
PART I: Assessment of general information of high risk antenatal mothers

Table 4- Represents Frequency and percentage distribution of demographic data (N=100)

GENERAL INFORMATION		Group			
		Primi		Multi	
		N	%	n	%
Age	20 -23 yrs	26	52.0%	10	20.0%
	24 -27 yrs	17	34.0%	18	36.0%
	28 -31 yrs	5	10.0%	13	26.0%
	32 -35 yrs	2	4.0%	9	18.0%
Education	Illiterate	2	4.0%	4	8.0%
	Primary	19	38.0%	19	38.0%
	Secondary	20	40.0%	14	28.0%
	Graduate	9	18.0%	13	26.0%
Religion	Hindu	38	76.0%	35	70.0%
	Christian	6	12.0%	10	20.0%
	Muslim	6	12.0%	5	10.0%
Employment status	Currently employed	2	4.0%	0	0.0%
	Currently unemployed	9	18.0%	12	24.0%
	Home maker	39	78.0%	38	76.0%
Type of family	Joint family	17	34.0%	25	50.0%
	Nuclear family	33	66.0%	25	50.0%
Family income	Rs.1000- 2000	4	8.0%	3	6.0%
	Rs.2000- 4000	25	50.0%	32	64.0%
	Rs.4000- 6000	21	42.0%	15	30.0%
Good support person	Yes	35	70.0%	39	78.0%
	No	15	30.0%	11	22.0%

The above Table shows that majority of high risk primigravida mothers belongs to 24-27 yrs of age are 34%, secondary education level is 40%, and nuclear family is 66%. The majority of high risk multigravida mothers belongs to 24-27 yrs of age are 36%, primary educational status is 38%, good support system is 78% and equal half in type of family.

GRAPH 4: AGE DISTRIBUTION AMONG HIGH RISK PRIMI AND MULTIGRAVIDAMOTHERS



Above graph shows the age distribution of high risk primigravida were age between 20-23 yrs is 52% and high risk multigravida mothers are in age between 24-27 yrs is 36%.

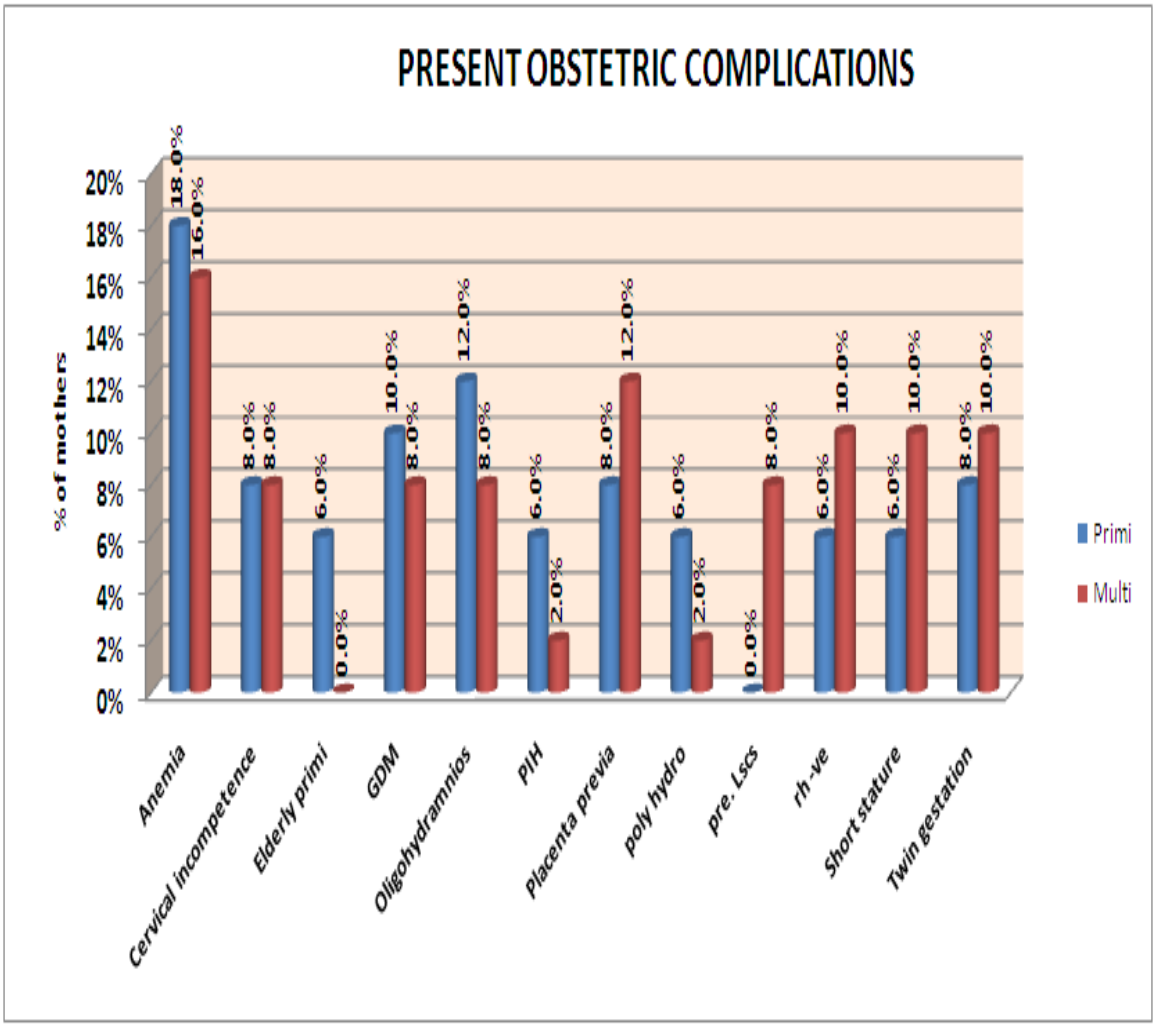
DISTRIBUTION OF OBSTETRICAL INFORMATION

Table 5: Frequency and percentage distribution of obstetrical information (N=100)

OBSTETRICAL INFORMATION		Group			
		Primi		Multi	
		N	%	N	%
Gestational age	28-32weeks	22	44.0%	11	22.0%
	33-36weeks	16	32.0%	21	42.0%
	37-40weeks	12	24.0%	18	36.0%
No. of pregnancy	One	50	100%	-	
	Two	-	-	50	100%
Planned Pregnancy	Yes	27	54.0%	23	46.0%
	No	23	46.0%	27	54.0%
Pregnancy registration	6-8 weeks	17	34.0%	10	20.0%
	8-10 weeks	23	46.0%	21	42.0%
	10-12 weeks	10	20.0%	19	38.0%
First antenatal visit	6-8 weeks	11	22.0%	5	10.0%
	8-10 weeks	22	44.0%	25	50.0%
	10-12 weeks	17	34.0%	20	40.0%
Presence of minor disorder	Yes	29	58.0%	31	62.0%
	No	21	42.0%	19	38.0%
Past medical complication	No	41	82.0%	39	78.0%
	Yes	9	18.0%	11	22.0%
Present obstetric complication	Anemia	9	18.0%	8	16.0%
	Cervical incompetence	4	8.0%	4	8.0%
	Elderly primi	3	6.0%	-	-
	GDM	5	10.0%	4	8.0%
	Hydramnios	6	12.0%	4	8.0%
	PIH	3	6.0%	1	2.0%
	Placenta previa	4	8.0%	6	12.0%
	poly hydro	3	6.0%	1	2.0%
	Pre. Lscs	-	-	4	8.0%
	Rh –ve	3	6.0%	5	10.0%
	Short stature	3	6.0%	5	10.0%
	Twin gestation	4	8.0%	5	10.0%
Antenatal counseling	Yes	16	32.0%	14	28.0%
	No	34	68.0%	36	72.0%

Above table shows that majority of high risk primigravida mothers was planned pregnancy is 54%, absence of past medical complication is 82%, and not attended antenatal counseling is 68%. The majority of high risk multigravida mothers was not planned pregnancy is 54% and not attended antenatal counseling is 72%.

GRAPH 5: PRESENT OBSTETRICAL COMPLICATION AMONG PRIMI AND MULTIGRAVIDA MOTHERS



The above graph shows the present obstetrical complication in which high risk primigravida mothers were 18% anemia complicating pregnancy,12% oligohydramnois and high risk multigravida mothers were 12% placenta previa and 12% oligohydrominos.

SECTION B

DISTRIBUTION OF MATERNAL PSYCHOSOCIAL ADAPTATION OF PRIMI GRAVIDA MOTHERS

Table: 6 Maternal psychosocial adaptation factors of high risk primigravida mothers

Factors Of Maternal Psychosocial Adaptation	No. of question	Min –max score	Mean	SD
Adaptation to present pregnancy	7	7 -35	24.90	2.25
Self adaptation	6	6 -30	18.18	1.42
Emotional adaptation	3	3 -15	11.64	1.37
Marital relationship	4	4 -20	14.42	1.20
Support system	6	6 -30	18.00	1.64
Sibling	3	3 -15	.00	.00
Materno-fetal adaptation	8	8 -40	23.90	1.43
Socio economic status	6	6 -30	17.10	1.76
OVERALL	**43**	**52 -158**	128.14	4.35

The above table represents that maternal psychosocial adaptation of high risk primigravida mothers. The majority were adapted to present pregnancy is 2.25; where else less in marital relationship was 1.20 by standard deviation.

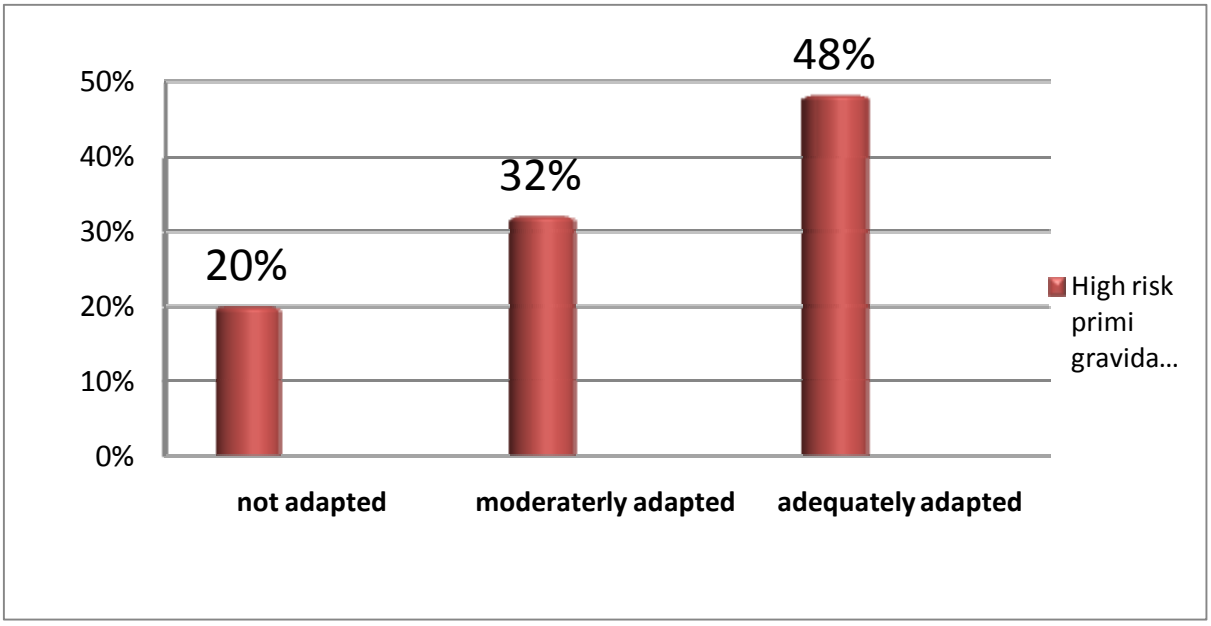
PART II: OVER ALL MATERNAL PSYCHOSOCIAL ADAPTATION OF PRIMI GRAVIDA MOTHERS

Table 7: Frequency and percentage distribution of overall psychosocial adaptation of high risk primigravida mothers.

LEVEL OF ADAPTATION	NO. OF MOTHERS	%
Not adapted	10	20.0%
Moderately adapted	16	32.0%
Adequately adapted	24	48.0%
Total	50	100%

Above table shows, high risk primigravida mothers level of maternal psychosocial adaptation. In general 24.0% of mothers are having adequate level adaptation and 16.0% of them having moderate level of maternal psychosocial adaptation and 10% are not adapted to maternal psychosocial adaptation.

GRAPH 6: OVER ALL MATERNAL PSYCHOSOCIAL ADAPTATION OF HIGH RISK PRIMIGRAVIDA MOTHERS



The above graph shows, among high risk primigravida mothers 48.0% are having adequate level adaptation, 32.0% of them having moderate level of maternal psychosocial adaptation and 20% are not adapted to maternal psychosocial adaptation.

SECTION C

DISTRIBUTION OF MATERNAL PSYCHOSOCIAL ADAPTATION OF HIGH RISK MULTIGRAVIDA MOTHERS

PART I: Assessment of maternal psychosocial adaptation of high risk multigravida mothers

Table 8: Maternal psychosocial adaptation of high risk multigravida mothers

Factors Of Maternal Psychosocial Adaptation	**No. of questions**	**Min –max score**	**Mean**	**SD**
Adaptation to present pregnancy	7	7 -35	26.70	2.15
Self adaptation	6	6 -30	20.70	2.00
Emotional adaptation	3	3 -15	11.30	.99
Marital relationship	4	4 -20	12.30	1.33
Support system	6	6 -30	18.56	1.64
Sibling	3	3 -15	10.56	1.16
Materno-fetal adaptation	8	8 -40	24.66	1.56
Socio economic status	6	6 -30	16.78	1.66
OVERALL	**43**	**52 -158**	128.14	4.74

The above table represents adaptation to present pregnancy is 2.15 and least was emotional adaptation is 0.99 by standard deviation for high risk multigravida mothers.

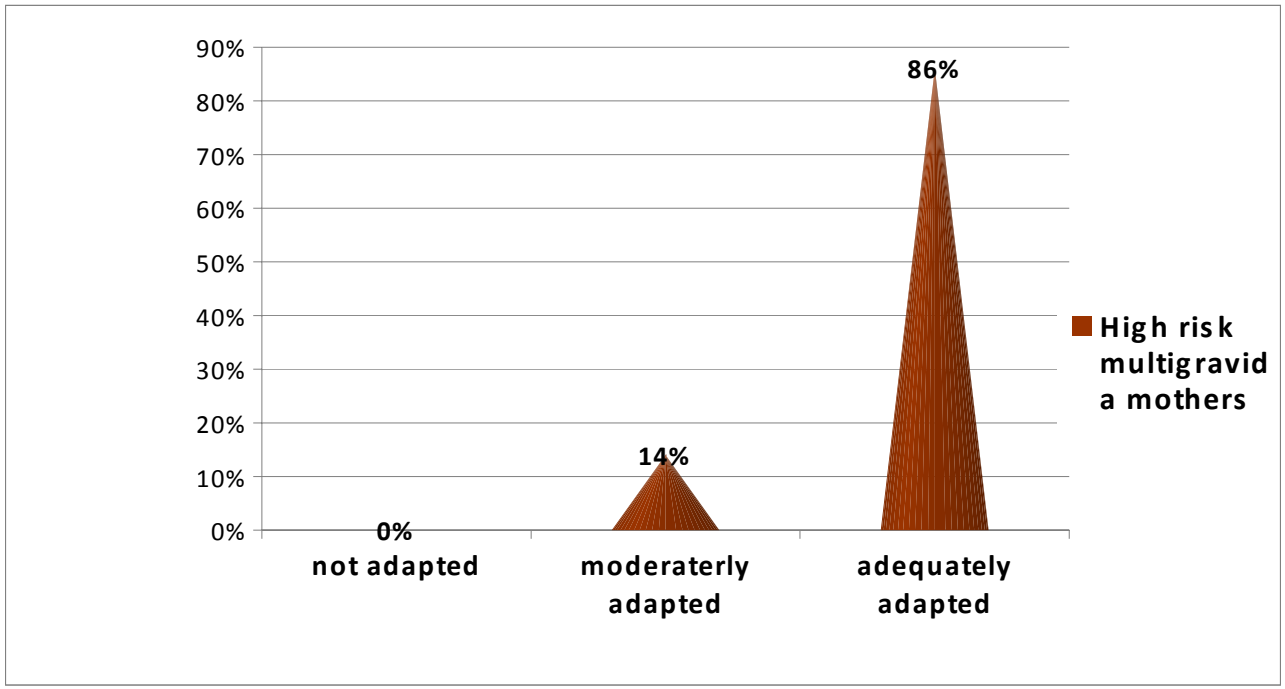
PART 2: OVER ALL FREQUENCY AND DISTRIBUTION OF MATERNAL PSYCHOSOCIAL ADAPTATION OF MULTI GRAVIDA MOTHERS

Table 9: Level of maternal psychosocial adaptation of high risk multigravida mothers

Level of adaptation	No. of mothers	%
Not adapted	0	0.0%
Moderately adapted	7	14.0%
Adequately adapted	43	86.0%
Total	50	100%

Above table shows, 14.0% of mothers are having moderate level adaptation and 86.0% of them having adequate level of maternal psychosocial adaption among high risk multigravida mothers.

GRAPH 7: OVERALL MATERNAL PSYCHOSOCIAL ADAPTATION OF HIGH RISK MULTIGRAVIDA MOTHERS



Above graph shows high risk multigravida mothers level of maternal psychosocial adaptation. In general 14.0% of mothers are having moderate level adaptation and 86.0% of them having adequate level of maternal psychosocial adaption.

SECTION- D

COMPARISON OF MATERNAL PSYCHOSOCIAL ADAPTATION OF HIGH RISK PRIMI AND MULTIGRAVIDA MOTHERS

Table 10: Comparison of maternal psychosocial adaptation factors between high risk primi and multigravida mothers

Factors of psychosocial adaptation	Primi		Multi		Student's independent t-test
	Mean	SD	Mean	SD	
Adaptation to present pregnancy	24.90	2.25	26.70	2.15	t=4.08 P=0.001 ***
Self adaptation	18.18	1.42	20.70	2.00	t=7.25 P=0.001 ***
Emotional adaptation	11.64	1.37	11.30	.99	t=1.42P=0.16
Marital relationship	14.42	1.20	12.30	1.33	t=8.38 P=0.001 ***
Support system	18.00	1.64	18.56	1.64	t=1.71 P=0.09
Sibling	.00	.00	10.56	1.16	t=64.18 P=0.001 ***
Materno-fetal adaptation	23.90	1.43	24.66	1.56	t=2.53P=0.01 ***
Socio economic status	17.10	1.76	16.78	1.66	t=0.93P=0.35
Overall	128.14	4.35	141.56	4.74	t=14.75 P=0.001***

* Significant at P≤0.05 ** highly significant at P≤0.01 *** very high significant at P≤0.001 DF=98

Above table shows the comparison of high risk primi and multigravida mothers adaptation score in each aspects of maternal psychosocial adaption score.

Considering Adaptation to present pregnancy, primigravida mothers scored 24.90, whereas multi gravid mothers scored 26.70, so the difference is 1.8. The difference between primi and multi gravid score is large and it is statistically significant (P= 0.001).

Considering Self adaptation, primi gravida mothers scored 18.18, whereas multigravida mothers scored 20.70, so the difference is 2.52. The difference between primi and multi gravid score is large and it is statistically significant (p= 0.001).

Considering Marital relationship, primi gravida mothers scored 14.42, whereas multigravida mothers scored 12.30so the difference is 2.12The difference between primi and multi gravida score is large and it is statistically significant(p= 0.001).

Considering Materno-fetal adaptation, primigravida mothers scored 23.90, whereas multi gravid mothers scored 24.66 so the difference is 1.06. The difference between primi and multi gravid score is large and it is statistically significant (0.01).

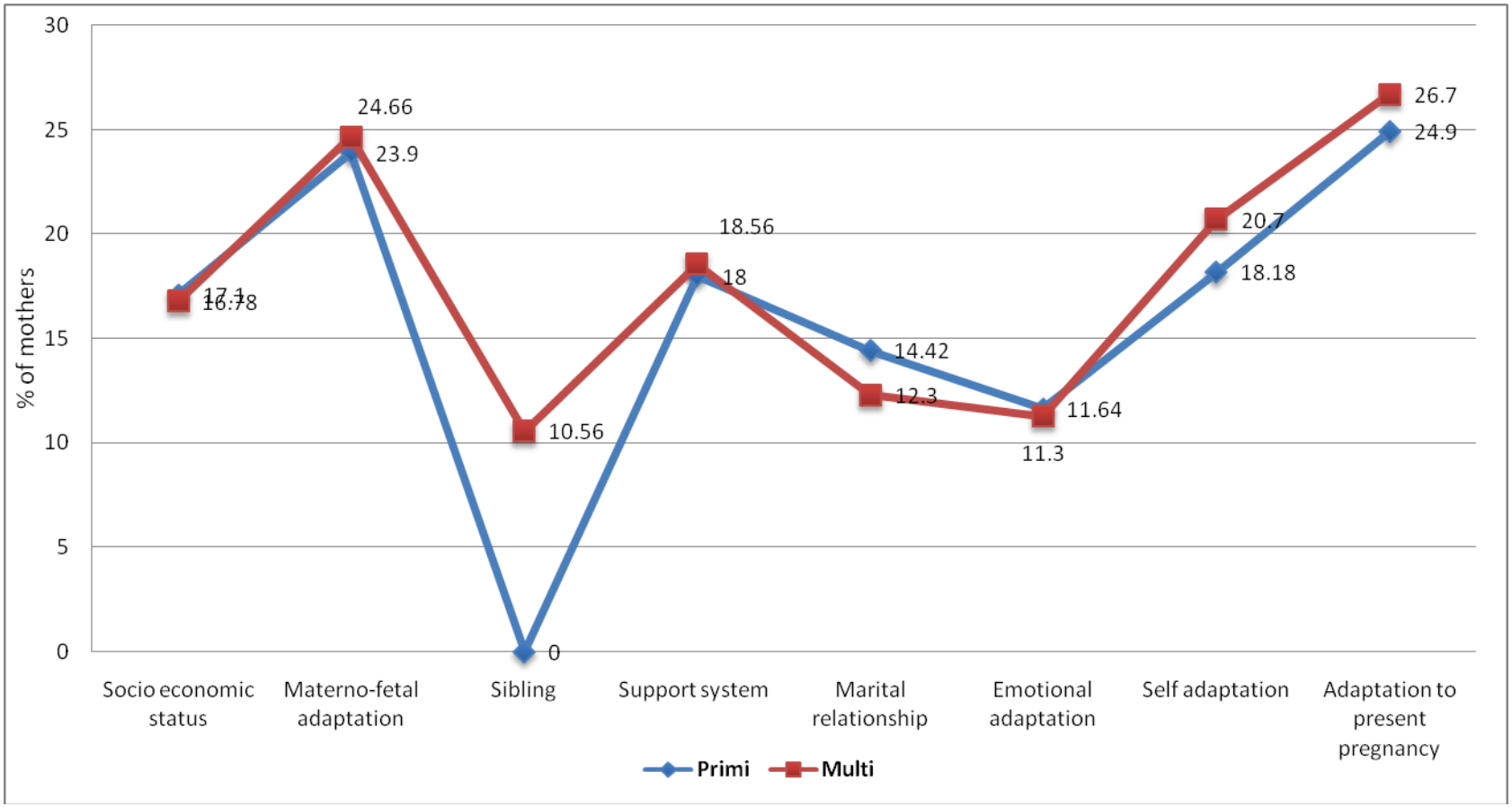
OVERALL COMPARISON OF MATERNAL PSYCHOSOCIAL ADAPTATION AMONG PRIMI AND MULTI GRAVIDA MOTHERS

Table 11: Comparison of overall level of maternal psychosocial adaptation among high risk primi and multigravida mothers.

Level of adaptation	Primi gravid mothers		Multi gravid mothers		Pearson Chi-Square test
	N	%	N	%	
Not adapted	10	20.0%	0	0.0%	$\chi 2=18.90 P=0.001^{***}$
Moderately adapted	16	32.0%	7	14.0%	
Adequately adapted	24	48.0%	43	86.0%	DF= 2 Significant
Total	50	100%	50	100%	

Above table shows that among high risk primigravida mothers 48.0% are having adequate level adaptation and 32.0% of them having moderate level of maternal psychosocial adaption and 20% are inadequately adapted to maternal psychosocial adaptation.Among high risk multigravida mothers 14.0% of mothers are having moderate level adaptation and 86.0% of them having adequate level of maternal psychosocial adaptation. Statistical significance was calculated by using Pearson chi-square test.There was statistically significant relationship between high risk primi and multigravida mothers in psychosocial adaptation (p=0.001).

GRAPH 8: COMPARISON OF MATERNAL PSYCHOSOCIAL ADAPTAION AMONG HIGH RISK PRIMI AND MULTIGRAVIDA MOTHERS



The above graph shows the comparison of maternal psychosocial adaptation among high risk primi and multigravida mothers represent that multigravida shows high adaptation than the primigravida mothers in certain aspects.

SECTION D

PART I: ASSOCIATION BETWEEN LEVEL OF ADAPTATION AND THEIR DEMOGRAPHIC VARIABLES OF HIGH RISK PRIMIGRAVIDA MOTHERS

Table: 12 Level of adaptation and their demographic variables of high risk primi gravida mothers

Demographic characteristics		Level of Adaptation						Total	Pearson chi square test
		Inadequate		Moderate		Adequate			
		n	%	n	%	n	%		
Age	20 -23 yrs	6	23.1%	8	30.8%	12	46.2%	26	$\chi 2=11.41 P=0.02 * DF=6$
	24 -27 yrs	1	5.9%	5	29.4%	11	64.7%	17	
	28 -31 yrs	2	40.0%	2	40.0%	1	20.0%	5	
	32 -35 yrs	1	50.0%	1	50.0%	0	00.0%	2	
Education	Illiterate	0	0.0%	0	0.0%	2	100.0%	2	$\chi 2=10.03 P=0.05 * DF=6$
	Primary	2	10.5%	7	36.8%	10	52.6%	19	
	Secondary	5	25.0%	5	25.0%	10	50.0%	20	
	Graduate	3	33.4%	4	44.4%	2	22.2%	9	
Employment status	Currently employed	0	0.0%	0	0.0%	2	100.0%	2	$\chi 2=5.05 P=0.28 DF=4$
	Currently unemployed	3	33.3%	1	11.1%	5	55.6%	9	
	Home maker	7	17.9%	15	38.5%	17	43.6%	39	
Type of family	Joint family	2	11.7%	2	11.7%	13	76.6%	17	$\chi 2=8.51 P=0.01 ** DF=2$
	Nuclear family	8	24.2%	14	42.4%	11	33.4%	33	
Family monthly income	Rs.1000-2000	1	25.0%	0	0.0%	3	75.0%	4	$\chi 2=2.81 P=0.59 DF=4$
	Rs.2000-4000	6	24.0%	8	32.0%	11	44.0%	25	
	Rs.4000-6000	3	14.3%	8	38.1%	10	47.6%	21	
Good support system	Yes	4	11.4%	9	25.7%	22	62.8%	35	$\chi 2=11.09 P=0.01 ** DF=2$
	No	6	40.0%	7	56.7%	2	13.3%	15	
Gestational age	28-32weeks	5	22.7%	7	31.8%	10	45.5%	22	$\chi 2=1.11 P=0.89 DF=4$
	33-36weeks	3	18.8%	4	25.0%	9	56.3%	16	
	37-40weeks	2	16.7%	5	41.7%	5	41.7%	12	

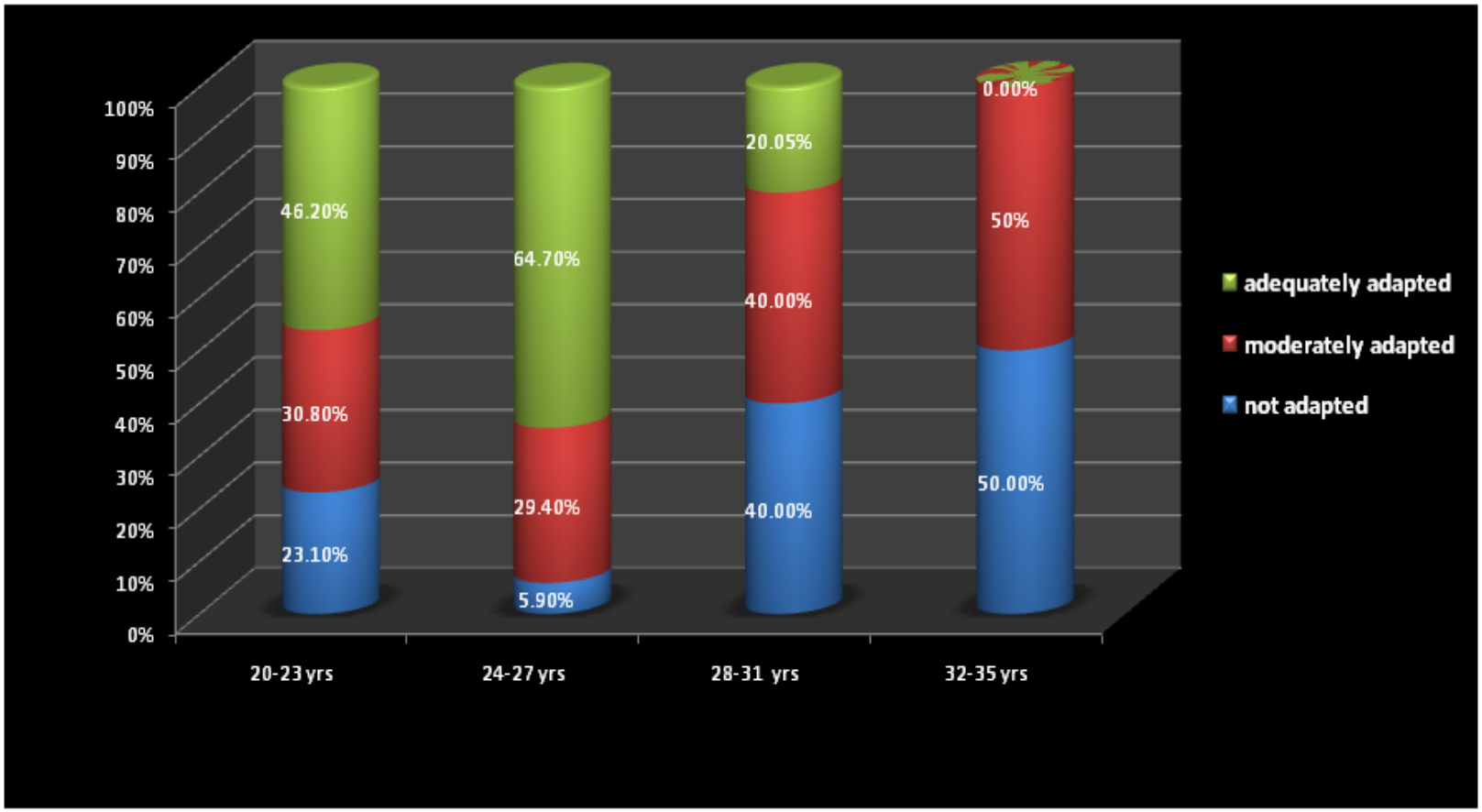
No. of pregnancy	One	10	20.8%	14	29.2%	24	50.0%	48	$\chi 2=4.42 P=0.11 DF=2$
	Two	0	0.0%	2	100.0%	0	0.0%	2	
Planned pregnancy	Yes	3	11.1%	8	29.6%	16	59.3%	27	$\chi 2=3.97 P=0.13 DF=2$
	No	7	30.4%	8	34.8%	8	34.8%	23	
Pregnancy registration	6-8 weeks	4	23.5%	7	41.2%	6	35.3%	17	$\chi 2=4.97 P=0.29 DF=2$
	8-10 weeks	6	26.1%	5	21.7%	12	52.2%	23	
	10-12 weeks	0	0.0%	4	40.0%	6	60.0%	10	
First antenatal visit	6-8 weeks	3	27.3%	2	18.2%	6	54.5%	11	$\chi 2=1.96 P=0.74 DF=2$
	8-10 weeks	3	13.6%	8	36.4%	11	50.0%	22	
	10-12 weeks	4	23.5%	6	35.3%	7	41.2%	17	
Presence of minor disorder	Yes	6	20.7%	8	27.6%	15	51.7%	29	$\chi 2=0.63 P=0.72 DF=2$
	No	4	19.0%	8	38.1%	9	42.9%	21	
Past medical complication	No	9	22.0%	12	29.3%	20	48.8%	41	$\chi 2=0.99 P=0.61 DF=2$
	Yes	1	11.1%	4	44.4%	4	44.4%	9	
Antenatal counseling	Yes	5	31.3%	4	25.0%	7	43.8%	16	$\chi 2=1.93 P=0.37 DF=2$
	No	5	14.7%	12	35.3%	17	50.0%	34	

The above table shows there is significant relationship between maternal psychosocial adaptations with age group between 24-27 yrs had 40% in moderate and inadequate level of adaptation among high risk primigravida mothers (p=0.02).

Also there is significant relationship between maternal psychosocial adaptation with education status of high risk primigravida in which graduates had 33% of inadequate level and 44% in moderate level of maternal psychosocial adaptation (p=0.05). Significant relationship was found between maternal psychosocial adaptation and family type of high risk primigravida, in which nuclear family 24% of them had inadequate and *42*% of them had moderate level of adaptation (p=0.01).

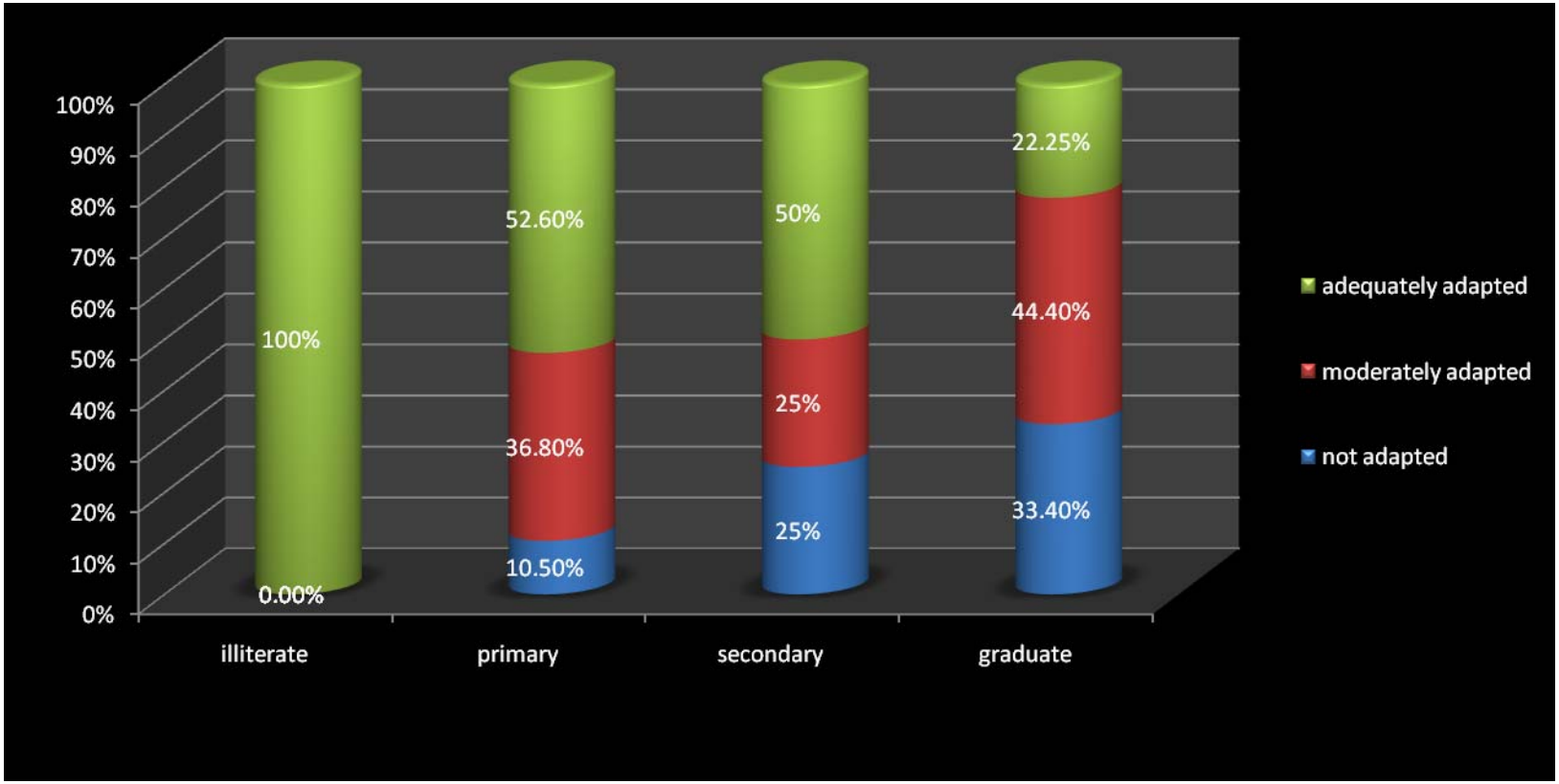
There is relationship between maternal psychosocial adaptation with support system of high risk primigravida; in which no support system was 40% had inadequate and 56.7% had moderate level of psychosocial adaptation (p=0.01).

GRAPH: 9 ASSOCIATION BETWEEN AGE AND LEVEL OF ADAPTATION AMONG HIGH RISK PRIMIGRAVIDA MOTHERS



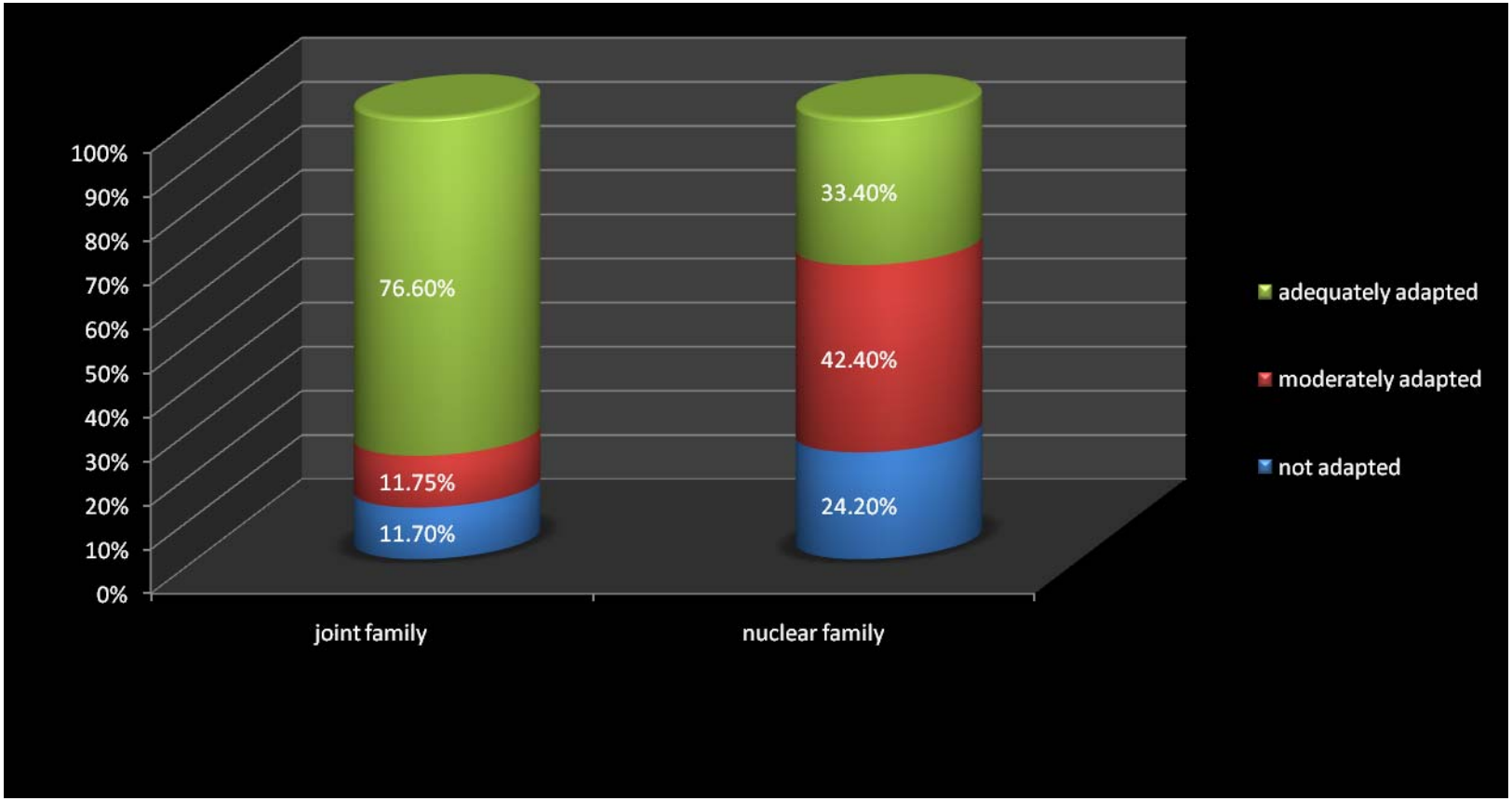
The above figure reveals there is significant relationship between maternal psychosocial adaptations with age group between 20 – 35 years among high risk primigravida mothers (P = 0.002).

GRAPH 10: ASSOCIATION BETWEEN LEVEL OF EDUCATIONAL STATUS AND LEVEL OF ADAPTATION AMONG HIGH RISK PRIMIGRAVIDA MOTHERS



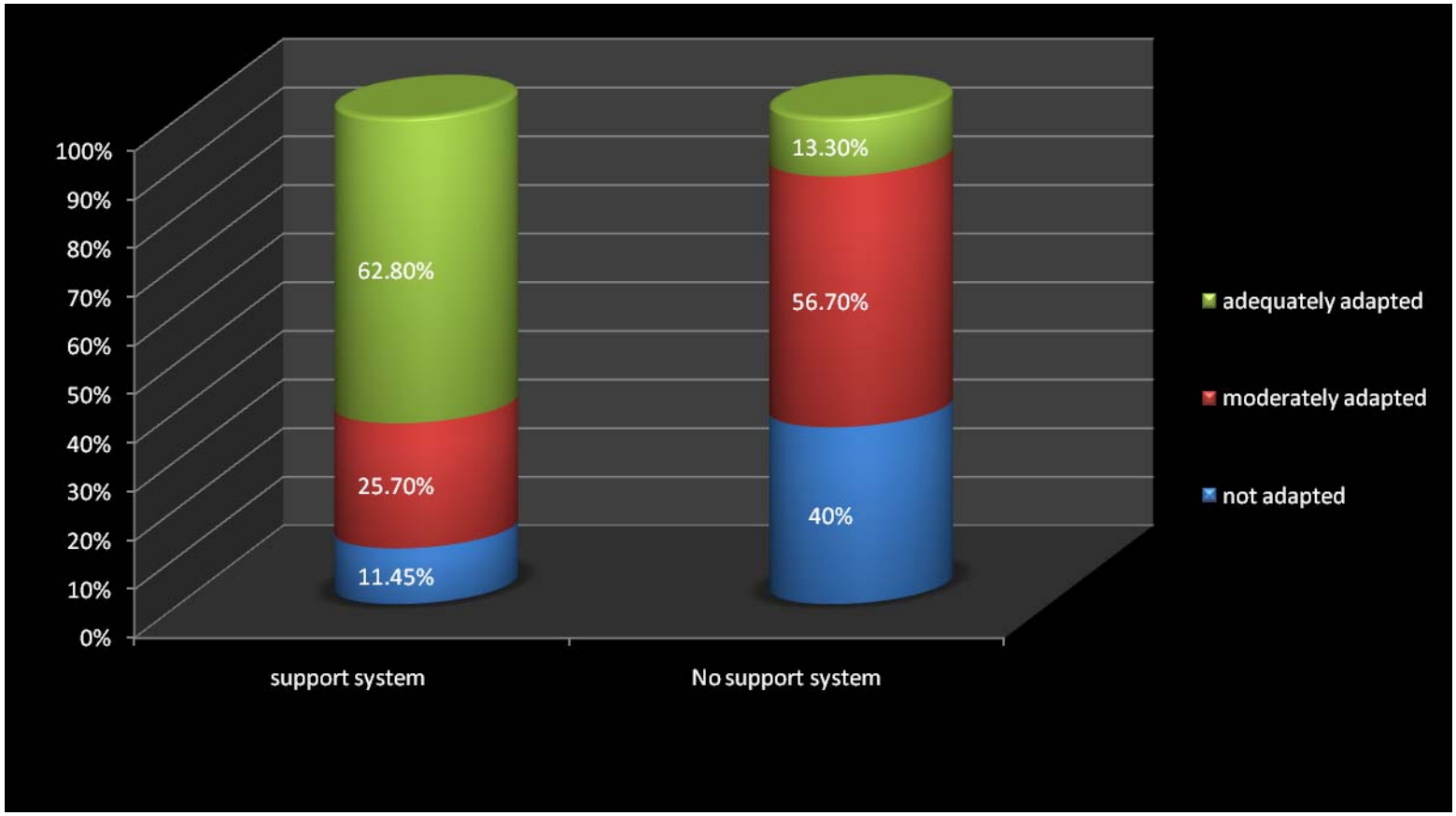
The above figure shows there is significant relationship between maternal psychosocial adaptations with educational status of high risk primi gravida mothers in which graduates had 33% of inadequate and 44% in moderate level of psychosocial adaptation (p= 0.05)

GRAPH 11: ASSOCIATION BETWEEN TYPE OF FAMILY AND LEVEL OF ADAPTATION AMONG high risk PRIMIGRAVIDA MOTHERS



The above figure shows there is significant relationship between psychosocial adaptation with type of family among high risk primigravida mother (p= 0.05).

GRAPH 12: **ASSOCIATION BETWEEN SUPPORT SYSTEM AND LEVEL OF ADAPTATION AMONG HIGH RISK PRIMIGRAVIDA MOTHERS**



The above figure shows there is significant relationship between maternal psychosocial adaptation with support system of high risk primigravida mothers (p= 0.001).

ASSOCIATION BETWEEN LEVEL OF ADAPTATION AND THEIR DEMOGRAPHIC VARIABLES OF HIGH RISK MULTIGRAVIDA MOTHERS

Part II: Association between level of adaptation and demographic variables of high risk multigravida mothers.

Table 13: Level of adaptation and demographic variables of high risk multigravida mothers.

DEMOGRAPHIC INFORMATION		Level of Adaptation				Total	Pearson chi square test
		Moderate		Adequate			
		n	%	n	%		
Age	20 -23 yrs	0	0.0%	10	100.0%	10	$\chi 2=7.85P=0.05*DF=3$
	24 -27 yrs	1	5.6%	17	94.4%	18	
	28 -31 yrs	2	15.3%	11	84.7%	13	
	32 -35 yrs	4	44.4%	5	55.5%	9	
Education	Illiterate	0	0.0%	4	100.0%	4	$\chi 2=8.86P=0.03*DF=3$
	Primary	1	5.2%	18	94.8%	19	
	Secondary	1	7.1%	13	92.9%	14	
	Graduate	5	38.4%	8	61.6%	13	
Employment status	Currently employed	1	8.3%	11	91.7%	12	$\chi 2=0.42P=0.51DF=1$
	Home maker	6	15.8%	32	84.2%	38	
Type of family	Joint family	0	0.0%	25	100.0%	25	$\chi 2=9.74P=0.01**DF=1$
	Nuclear family	7	28.0%	18	72.0%	25	
Family monthly Income	Rs.1000- 2000	1	33.3%	2	66.7%	3	$\chi 2=0.99P=0.61DF=2$
	Rs.2000- 4000	4	12.5%	28	87.5%	32	
	Rs.4000- 6000	2	13.3%	13	86.7%	15	
Good support System	Yes	6	15.4%	33	84.6%	39	$\chi 2=7.72P=0.01**DF=1$
	No	1	9.1%	10	90.9%	11	
Gestational age	28-32weeks	3	27.3%	8	72.7%	11	$\chi 2=2.08P=0.35DF=2$
	33-36weeks	2	9.5%	19	90.5%	21	
	37-40weeks	2	11.1%	16	88.9%	18	

No. of pregnancy	One			1	100.0%	1	χ2=0.17P=0.68DF=1
	Two	7	14.3%	42	85.7%	49	
planned Pregnancy	Yes	5	21.7%	18	78.3%	23	χ2=2.11P=0.15DF=1
	No	2	7.4%	25	92.6%	27	
Pregnancy registration	6-8 weeks	2	20.0%	8	80.0%	10	χ2=0.49P=0.78DF=2
	8-10 weeks	3	14.3%	18	85.7%	21	
	10-12 weeks	2	10.5%	17	89.5%	19	
Presence of minor disorder	Yes	7	22.5%	24	77.5%	31	χ2=7.64P=0.01**DF=1
	No	0	0.0%	19	100.0%	19	
Past medical complication	No	5	12.8%	34	87.2%	39	χ2=0.20P=0.65DF=1
	Yes	2	18.2%	9	81.8%	11	
Antenatal counseling	Yes	2	14.3%	12	85.7%	14	χ2=0.01P=0.97DF=1
	No	5	13.9%	31	86.1%	36	

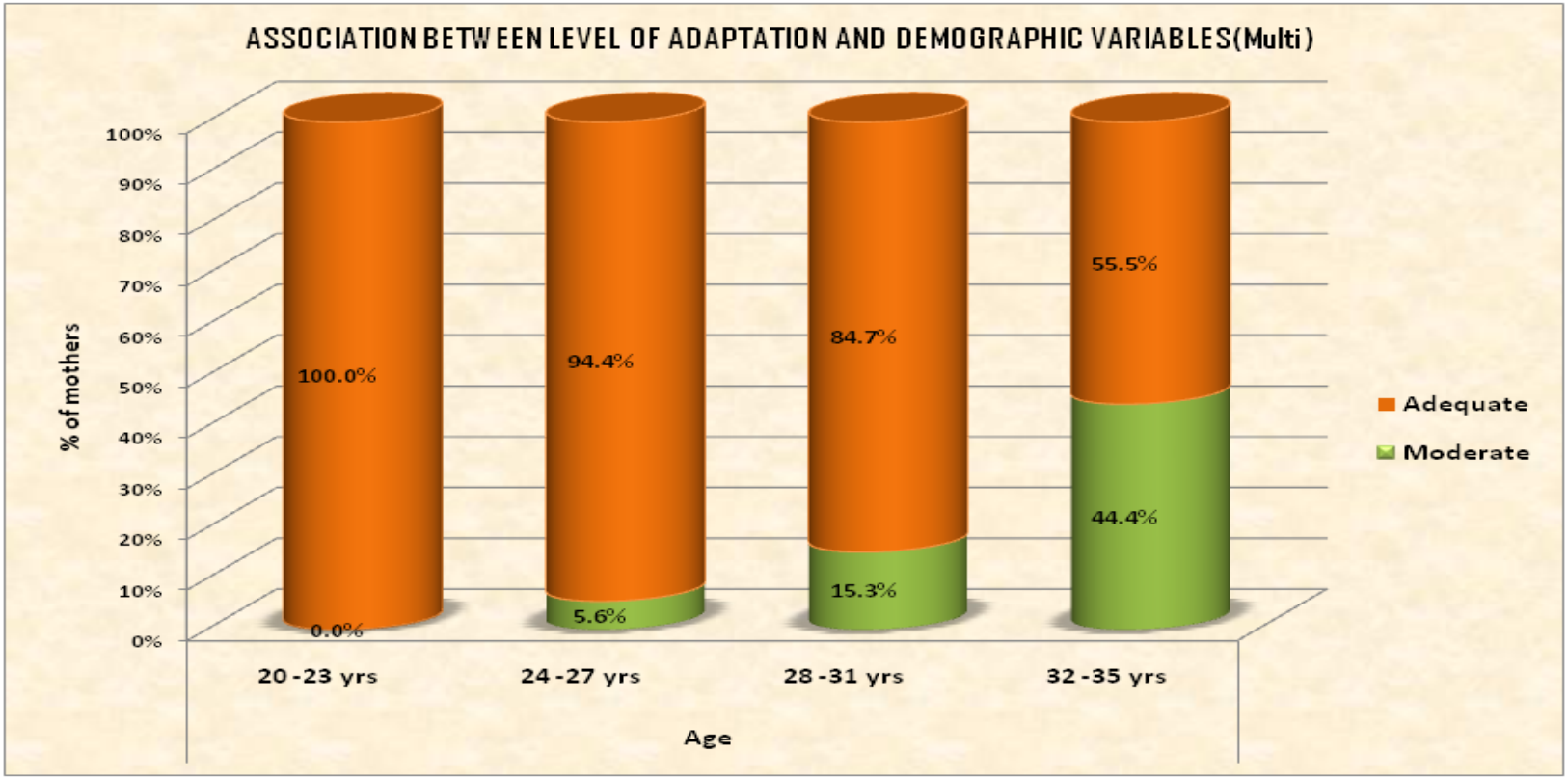
* significant at P≤0.05 ** highly significant at P≤0.01 *** very high significant at P≤0.001

Above table shows that there is significant relationship between maternal psychosocial adaptations with age group between 30-34 yrs had 44.4% in moderate and 55.5% inadequate level of adaptation among high risk multigravida mothers (p=0.05).

Also there is significant relationship between maternal psychosocial adaptation with education status of high risk multigravida mothers in which graduates had 38.4% in moderate level and 61.1% in adequate level of maternal psychosocial adaptation (p=0.03).

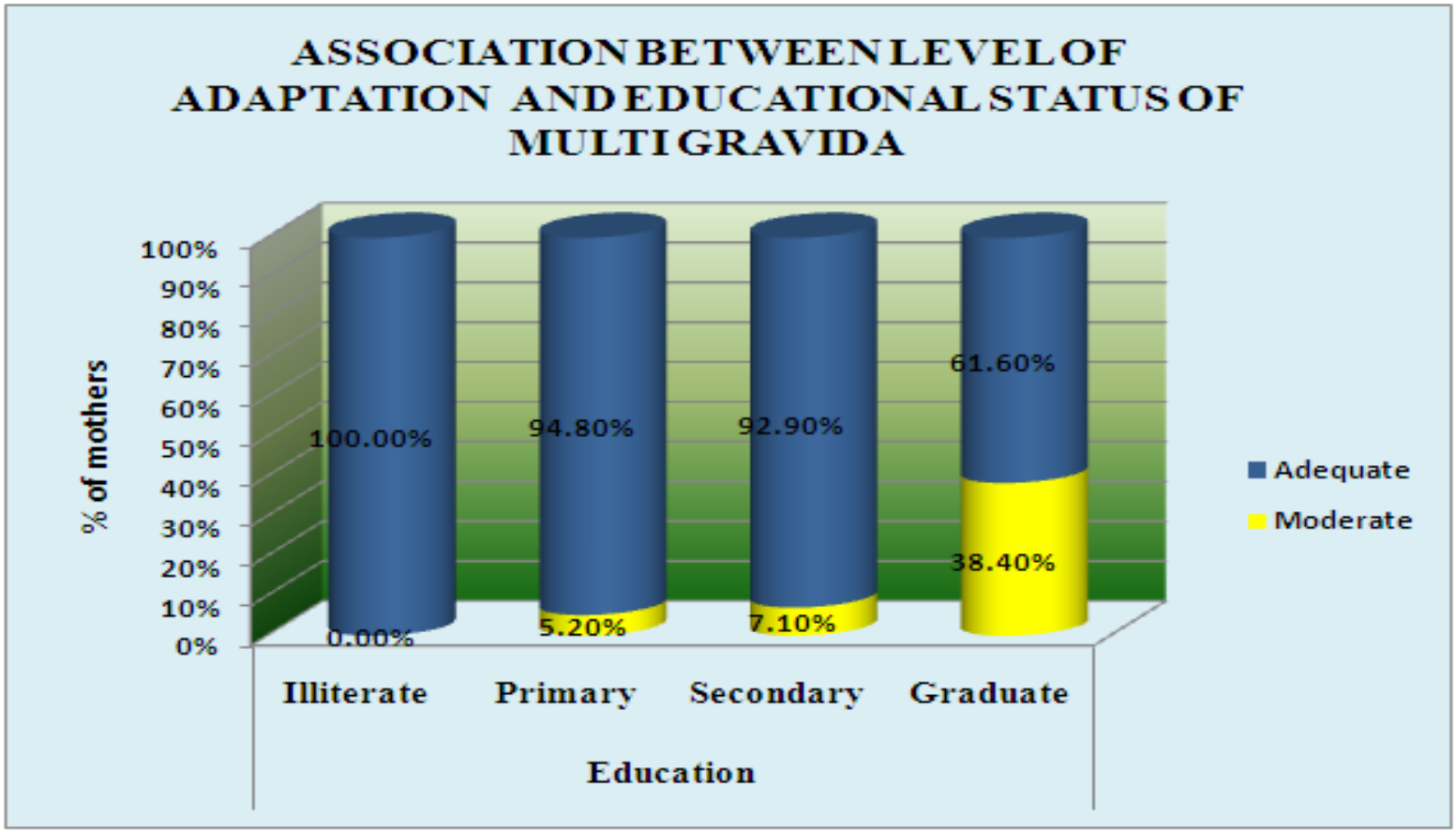
Significant relationship was found between maternal psychosocial adaptation and family type of high risk multigravida mothers, in which joint family had 100% of adequate level of adaptation (p=0.01). There is significant relationship between maternal psychosocial adaptation with support system of high risk multigravida mothers; in which good support system was 84.6% had adequate and 15.4% had moderate level of psychosocial adaptation (p=0.01).

GRAHP 13: ASSOCIATION BETWEEN LEVEL OF ADAPTATION AND AGE GROUP AMONG HIGH RISK MULTIGRAVIDA MOTHERS



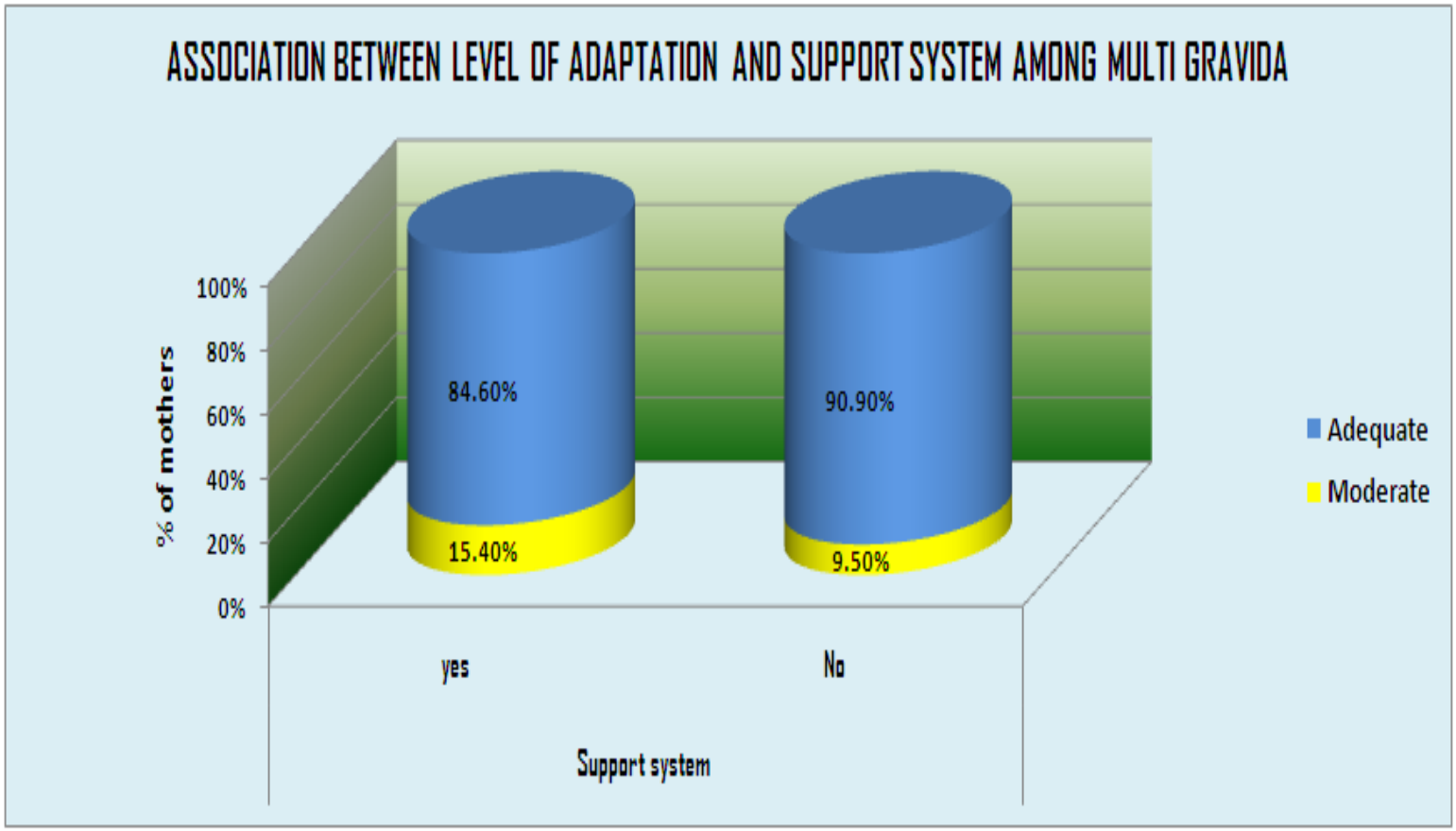
The above graph shows there is significant relationship between maternal psychosocial adaptation and age group in which 32-35 yrs had 44.4% at moderate level and 55.5% at inadequate level among multi gravida mothers (p= 0.05).

GRAPH 14: ASSOCIATION BETWEEN LEVEL OF PSYCHOSOCIAL ADAPTATION AND EDUCATIONAL STATUS AMONG HIGH RISK MULTIGRAVIDA MOTHERS



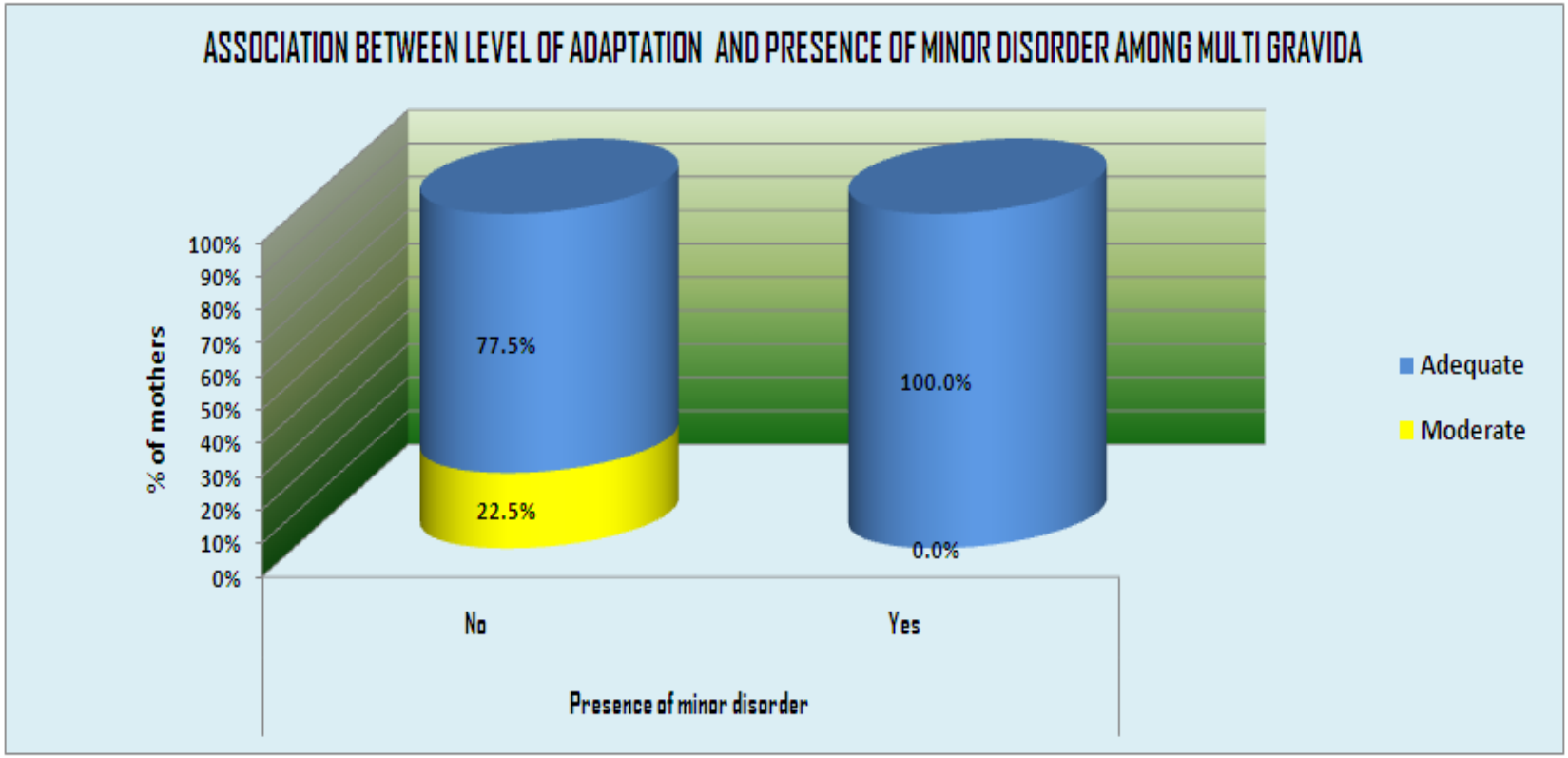
The figure shows there is significant relationship between psychosocial adaptation and educational status in which graduates had 38.4% at moderate level and 61.1% at inadequate level among high risk multigravida mothers (p= 0.03).

GRAPH 15: ASSOCIATION BETWEEN LEVEL OF PSYCHOSOCIAL ADAPTATION AND SUPPORT SYSTEM AMONG HIGH RISK MULTIGRAVIDA MOTHERS



The above graph shows there is significant relationship maternal psychosocial adaptation and support system in which good support system had 84.6% at adequate level and 15.4% in moderate level among high risk multigravida mothers (p= 0.01).

GRAPH 16: ASSOCIATION BETWEEN LEVEL OF PSYCHOSOCIAL ADAPTATION AND PRESENCE OF MINOR DISORDER IN HIGH RISK MULTIGRAVIDA MOTHERS



The above figure reveals there is significant relationship between levels of adaptation with presence of minor disorder among high risk multigravida mothers (p= 0.01).

CHAPTER - V

DISCUSSION

The study aimed to assess the maternal psychosocial adaptation of high risk primi and multigravida mothers in the Institute of Obstetric and Gynaecology, Hospital for Women and Children, Chennai. A total of 100 samples were selected by simple random sampling technique based on inclusion criteria, so that strategies for adaptation can be intensified; thereby able to minimize the complication of pregnancy outcome.

Twenty million low birth weight babies are born per year. 95% are from developing countries, 60% die during first postnatal week and 40% of them are less than 1500gm. Pregnancy is a maturational or developmental life crisis. It is a critical period in which normal situations in the life cycle alter one's equilibrium, resulting in the initiation of coping mechanism to adapt.

The justification of undertaking this study based on level of maternal psychosocial adaptation to present pregnancy among high risk mothers contributes to abnormal pregnancy outcome like operative deliveries, low birth weight babies, IUGR, and preterm deliveries.

The investigator recorded the response of the mothers in the questionnaire and latter coded the response as adequately adapted is five and not adapted is one in form of rating scale. After collecting the data, statistical analysis was done using descriptive and inferential statistical methods such as mean, standard deviation and chi- square test. Score interpretation was made for level of psychosocial adaption as follows;

Minimum score: 52 maximum score: 158

Not adapted: <52

Moderately adapted: 53 - 105

Adequately adapted: 106 – 158

Discussion of the current study was based on the following objectives:

DEMOGRAPHIC AND OBSTETRICS VARIABLES OF HIGH RISK PRIMI AND MULTIGRAVIDA MOTHERS

Mothers selected for this study were belonging to age group between 20 to 35 years of age. A similar comparative study was conducted by **Heaman. M** with age group between 20 to 35 aged of primi mothers. Result shows that pregnant women of advanced maternal age were significantly more likely to be better educated, to have higher income, to be employed, and to continue to work until the end of pregnancy than younger women.

The main study shows that high risk primigravida mothers belong to age between 20-23 yrs and 24-27 yrs is 52 %and 34%, they were educated up to primary and secondary level was 38% and 40%.

The main study revealed that high risk multigravida mothers belong to age group between 24-27 yrs and 28-31 yrs was 36% and 26%, there majority of educational status was primary and secondary level was 38% and 28%.

The main study shows that present obstetrical complication of primigravida mothers were 18% anemia complicating pregnancy and 12% oligohydramnoius where else in high risk multigravida mothers had 12% placenta previa and 12% oligohydrominos.

The similar study was also conducted by **Chalners et al** in 1999, attempted to explain obstetric difficulties on the basis of psychosocial conditions which exist during pregnancy. Reported that age at birth of first child, educational level, menstrual history, attitude to pregnancy and age at menstruation best predict obstetric difficulties.

FIRST OBJECTIVE: ASSESSMENT OF MATERNAL PSYCHOSOCIAL ADAPTATION OF HIGH RISK PRIMIGRAVIDA MOTHERS

Chou WJ, reported that rate of psychological distress was 70% and marked depression was 24% among primigravida mothers in Taiwan. The present study also identified that 48% of high risk primigravida mothers are adequately adapted, 32% of them are moderately adapted, and 20% are not adapted to maternal psychosocial adaptation to present pregnancy.

The similar also conducted by **Ip al**, 2000 at Hong Kong in which 45 primigravida woman had attended antenatal classes and their partner present during labour. reported that there is no significant association between level of emotional support and maternal outcome measures, but perceived practical support was positively related to the dosage of pain relieving drug used and total length of labour.

SECOND OBJECTIVE: ASSESSMENT OF MATERNAL PSYCHOSOCIAL ADAPTATION OF HIGH RISK MULTIGRAVIDA MOTHERS

Emmanuel E, reported in analyzing the concept of maternal distress that four attributes of maternal distress was identified; stress, adapting, functioning and control, connecting. Thus maternal distress offers a comprehensive approach to understanding in maternal emotional health during transition to motherhood.

The present study shows great evident that majority of high risk multigravida mothers have adequate maternal psychosocial adaptation is 86% and remaining 14% are in moderately adapted to maternal psychosocial adaptation.

THIRD OBJECTIVE: COMPARISON OF MATERNAL PSYCHOSOCIAL ADAPTATION BETWEEN HIGH RISK PRIMI AND MULTIGRAVIDA MOTHERS

Lin CT, reported in the cross sectional and comparative study that primi gravida mothers had poorer maternal psychosocial adaptation than multi gravida, shows that there is significant difference between two samples in terms of concern for well-being of self and baby, fear of helplessness and loss of control in labour.

The current study shows the factors of maternal psychosocial adaptation between high risk primi and multigravida mothers to present pregnancy, self adaptation, marital relationship and sibling adaption was statistically very high significant (p= 0.001), materno- fetal adaptation is statistically highly significant (p=0.01). Over all comparison of maternal psychosocial adaptation between high risk primi and multigravida mothers was statistically very high significant (p=0.001).

FOURTH OBJECTIVE: ASSOCIATION BETWEEN LEVEL OF MATERNAL PSYCHOSOCIAL ADAPTATION AND THEIR DEMOGRAPHIC VARIABLES OF HIGH RISK PRIMI AND MULTIGRAVIDA MOTHERS

Heaman. M reported that age group between 20 to 30 years of age. Result shows that pregnant women of advanced maternal age were significantly more likely to be better educated, to have higher income, to be employed, and to continue to work until the end of pregnancy than younger women.

The main study also interpret that high risk primigravida mothers belongs to age group between 24-27 yrs is 64% having adequate level of maternal psychosocial adaptation(p=0.02)

The present study revealed that primary and secondary level of educational status of high risk primigravida mothers is 52 and50% which was high proportion to the adequate level of psychosocial adaptation (p=0.05)

Senturk V, reported in cross sectional survey that prevalence of case level depression was 33.1% and this was associated with lower social support but not with nuclear family or traditional family structure.

The present study shows that support system of high risk primigravida mothers is 62.8% which was highly proportionate to the adequate level of maternal psycho social adaptation (p=0.01).

The similar study was also conducted by **Villar et al**, in Canada regarding influence of maternal stress, social support and life styles over the course of pregnancy.63% of women experienced pregnancy complication reported high level of state anxiety during hassles and pregnancy specific stress. The result indicates that certain psychosocial and life style variables may be differentially associated with complication accordingly at various phases of pregnancy.

The current study revealed that age group between 23-27 yrs of high risk multigravida mothers is 94.4% are independent factors in adequate level of maternal psychosocial adaptation.

The current study revealed that high risk multigravida mothers belong to joint family have higher proportionate of 100% in adequate level of maternal psychosocial adaptation.

HYPOTHESIS

There is a statistical significant association between high risk primi and multigravida mothers in maternal psychosocial adaptation in which high risk primi gravida mothers were 20% not adapted and 32% moderately adapted. Where else high risk multigravida mothers 14% moderately adapted and 865 adequately adapted. Hence there is a statistical significant association of P=0.001 between high risk primi and multi gravida mothers.

The similar study was also conducted by **Lobel. M**, et al, 1999, in New York to assess the coping and distress among 167 pregnant women at high medical risk. The result shows moderately high level of distress about physical symptoms, weight gain and having an unhealthy baby. Sociodemographics variables including age, income, education, and parity were significantly associated with ways of coping.

Hence the hypothesis was accepted.

CHAPTER VI

SUMMARY

India at present contributes 10% of the world's low birth weight infants. An all rounded approach to the pregnant mother and her health care is therefore necessary to minimize in every way possible the risk of such maternal and fetal outcome. Proper counseling for the mother and her family with stress on the support system is required.

Antenatal visit of the mother can be combined with counseling regarding pregnancy and her adjustment to the change involved. The father of the child may also be involved and the importance of his support, emotional and otherwise to the patient emphasized. The social support network of the mother may also be assessed and if possible, the client encouraged utilizing it to the fullest event. Stress coping technique and reduction as to healthful behavior during the pregnancy would also prove beneficial. In other words, a holistic approach to antenatal care of the pregnant woman and her family may be adopted to obtain a better perinatal outcome.

Thus midwife is in unique position to educate and empower women through the phases of child birth in order for them to achieve healthy pregnancy with optimum outcome of healthy baby – **Karen Blakey**

MAJOR FINDINGS OF THE STUDY:

- The majority of high risk primigravida mothers belongs to age group between 20-23 are 52%
- The majority of high risk multigravida mothers belongs to age group between 24-27 are 36%
- The majority of high risk primigravida where educated at secondary level are 40%
- The majority of high risk multigravida mother where educated at primary level are 38%
- The majority findings shows that 54% of high risk primi gravida mothers was pregnancy planned and 54% of high risk multigravida was pregnancy unplanned.

- The major finding shows that 58% of high risk primi and 62% of high risk multigravida was suffering with minor disorder during present pregnancy.
- The overall maternal psychosocial adaptation to present pregnancy of high risk primigravida mothers was adequately adapted to 48%, and not adapted to 20%
- The overall maternal psychosocial adaptation to present pregnancy of high risk multigravida was adequately adapted i.e. 86%.
- There is statistically significant relationship between adaptation to present pregnancy and maternal psychosocial adaptation of high risk primigravida mothers(p=0.001)
- There is statistically significant relationship between self adaptation and maternal psychosocial adaptation of high risk primigravida mothers (p=0.001)
- There is statistically significant relationship between marital relationship and maternal psychosocial adaptation of high risk primigravida mothers (p0.001)
- There is statistically significant relationship between materno-fetal adaptation and maternal psychosocial adaptation of high risk primigravida mothers (p=0.001)
- Majority findings shows that statistically significant in maternal psychosocial adaptation between primi and multigravida mothers (p=0.001)
- There is statistically significant association between age and level of psychosocial adaption of primigravida mothers (p=0.02)
- There is statistically significant association between level of education and level of psychosocial adaption of primigravida mothers (p=0.05)
- There is statistically significant association between type of family and level of psychosocial adaption of primigravida mothers (p=0.01)
- There is statistically significant association between support system and level of psychosocial adaption of primigravida mothers (p=0.01)
- There is statistically significant association between age and level of psychosocial adaption of multigravida mothers (p=0.05)
- There is statistically significant association between level of education and level of psychosocial adaption of multigravida mothers (p=0.03)
- There is statistically significant association between type of family and level of psychosocial adaption of multigravida mothers (p=0.01)

- There is statistically significant association between support system and level of psychosocial adaption of multigravida mothers (p=0.01)
- There is statistically significant association between minor disorder and level of psychosocial adaption of multigravida mothers (p=0.01)

CONCLUSION:

Pregnancy is clearly one of the most profound psychological events in a human life. It is the ultimate psychosomatic experience (**Donald Sloan**, 1994). Pregnancy is a maturational or developmental life crisis. A maturational crisis is critical period in which a normal situation in the life cycle alters one's equilibrium, resulting in the initiation of coping mechanism to adapt. If these coping mechanism do not work, crisis occurs. The midwife will come to know that importance of assessment in the psychosocial influence affecting pregnant women plays a role in improving the perinatal outcome (**Williams**).

Emotional wellbeing influence physical wellbeing and any plan for the woman's care during pregnancy may include on assessment of her psychological response. Attention to this component of the women's health status is also crucial because her psychological adaptation during pregnancy will certainly be directly related to her adaptation to the mothering role after birth.

NURSING IMPLICATION

The midwife is recognized as a responsible and accountable professional who works in partnership with women to give the necessary support, care and advice during pregnancy, labour and the postpartum period, to conduct births on the midwife's own responsibility and to provide care for the newborn and the infant. This care includes preventive measures, promotion of normal birth, detection of complications in mother and child, accessing of medical or other appropriate assistance and carrying out of emergency measures.

NURSING EDUCATION:

- Demonstrate the knowledge and competence in comprehensive approach of pregnant women
- The present study would help nursing students to understand the advantages and importance of maternal psychosocial adaptation and provide need based care to the mother
- This study would help the student nurses to understand the importance of educating women in pre pregnant state.

NURSING SERVICE:

- Act as catalyst in advocating for Planned Parenthood
- Psychosocial screening at each trimester helps to identify adverse pregnancy outcome.
- Provides client with information regarding health care decision and the state of science regarding these choice to allow for informed decision making.
- Apply established competencies to provide guide for family members in client care
- Promote involvement of support person in the practice setting
- Midwives responsible to the psychological, physical, emotional, and spiritual needs of the women seeking health care.
- Provide care for women and childbearing families with respect for cultural diversity

NURSING RESEARCH

- Develop and share knowledge through a variety of processes, such as peer review and research
- Maintains knowledge and skills through actively participating in continuing Professional development programs
- Uses valid research to inform midwifery practice
- Identifies opportunities and contributes to nursing research
- Refers to and disseminates current research to guide midwifery practice

NURSING ADMINISTRATION

- Construct and implement protocol to assess psychological assessment for the antenatal mothers as a part of routine antenatal visit
- Strengthen involvement of nurses in delivering comprehensive approach to the mothers
- Establish a quality assurance system- ensuring the achievement of good Perinatal outcome

RECOMMENDATIONS

- Similar study can be conducted on large sample (<200).
- Same study can be replicated in another setting.
- A study can be done to assess the present standard of nursing care, rendered to the high risk antenatal mothers.
- Comparative study between primi and multigravida mothers on specific factors of maternal psychosocial adaptation like self and emotional adaptation can be conducted.
- A longitudinal study can be done to assess psychosocial adaptation and its pregnancy outcome.
- A comparative study can be conducted in rural and urban areas to assess the quality of care rendered to the antenatal mothers

- A study can be conducted on nursing personnel to identify knowledge, attitude and practice of psychosocial adaptation during pregnancy
- A similar study can be conducted with healthy antenatal mothers
- A similar study can be conducted with any one obstetric complication like placenta previa, hypertensive disorder during pregnancy.
- A study can be conducted on effectiveness of psychosocial preparation during antenatal period and its outcome on delivery.
- A qualitative study can be conducted to assess psychosocial adaptation of pregnant women.

LIMITATIONS

- The study was limited to only third trimester high risk antenatal mothers.
- Samples were limited to 50 primi and 50 multigravida high risk mothers.
- Only selected past medical and present obstetric complications of primi and multi gravida was included.
- Samples were not included like unmarried and adolescent pregnancies.
- Multi parity and grand multi gravida was not included in this study
- Mothers who are in labour pain (active stage) are not included.

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RESEARCH TOOL

SECTION A: General Information

SAMPLE NO:

1. **Age** [ ]

a) 20-23 yrs

b) 24-27 yrs

c) 28-31 yrs

d) 32-35 yrs

2. **Educational qualification** [ ]

a) Illiterate

b) Primary education

c) Secondary education

d) Graduate

3. **Religion** [ ]

a) Hindu

b) Christian

c) Muslim

d) Others

4. **Employment status** [ ]

a) Currently employed

b) Currently unemployed

c) Home maker

d) Business

5. **Type of family** [ ]

a) Joint

b) Nuclear

c) Extended

6. Family monthly income

a). 1000- 2000
b). 2000- 4000
c). 4000- 6000

7. **Do you have good support person**?

a. Yes

b. No if yes specify----------

SECTION B- OBSTETRICAL DATA

1. Gestational age of the mother ----------

a) 28-32weeks

b) 33-36 weeks

c) 37-40 weeks

2. Number of pregnancy is [ ]

a) I

b) II

c) III

3. Was pregnancy planned? [ ]

a) Yes

b) No

4. Pregnancy was registered at----------

a) 6-8 weeks

b) 8- 10 weeks

c) 10-12 weeks

d) 12 – 14 weeks

5. **The first antenatal visit was within** [ ]

a) 6- 8 weeks

b) 8- 10 weeks

c) 10 – 12 weeks

d) 12- 14 weeks

6. **Do you suffering with minor disorder related to pregnancy**? [ ]

   a. Yes

   b. No

7. **Presence of past medical/ surgical complication**

   (From client health record)

8. **Present pregnancy related complication**

   (From client health record)

9. **Did you attend any counseling regarding antenatal care?** [ ]

a) Yes

b) No

SECTION: C

Modified Antenatal Psychosocial Health Assessment (ALPHA)

SNO	CONTENT	Strongly agree (5)	Agree (4)	Uncertain (3)	Disagree (2)
A.	**ADAPTATION TO PRESENT PREGNANCY**				
1.	I feel confident in my ability to cope with my pregnancy				
2.	I feel satisfied being pregnant				
3.	I feel confident imagining myself as mother				
4.	I feel nervous about being a mother				
5.	I feel confident that I will be able to manage the added cost of a new baby				
6.	I feel confident that I will be able to take care of my newborn				
7.	I feel worried that I will have difficulty in feeding my baby				
B.	**SELF ADAPTATION**				
8.	I feel satisfied that I am taking good care of myself				

9.	I feel concerned that my age will effect on pregnancy					
10.	I feel frightened that I may die					
11.	I feel comfortable with the weight I have gained					
12.	I feel concerned about my health					
13.	I feel worried that I won't get my figure back after my baby is born					
C	**EMOTIONAL ADAPTATION**					
14.	I feel confused because of my changing mood					
15.	I feel tense due to lack of sleep, difficulty concentrating or irritability					
16.	I feel tense because I want pregnancy to be completed.					
D.	**MARITAL RELATIONSHIP**					
17.	I feel satisfied with my partner involvement in my pregnancy					
18.	I feel confident that my partner will be a good parent					
19.	I feel tense because my partner and I argue a lot					
20.	I feel nervous having sex, because it might harm my baby or start labour.					
E	**SUPPORT SYSTEM**					
21.	There is someone I feel close to who makes me feel secure					

22.	There are people who are available if I need help over an extended period of time				
23.	There is someone who love and care about me				
24.	I have people to share social events and fun activities				
25.	I have sense of being needed by another person				
26.	I have enough contact with the person who makes me feel special				
F.	**SIBLING**				
27.	I feel worried about how I am going to care for my other child				
28	I feel concerned that my other child might feel I won't have a much love for them				
29	I feel concern with my first child reaction to the news about the new baby.				
G.	**MATERNO- FETAL ADAPTATION**				
30	I feel confident that I will be able to manage the added weight of the fetus				
31	I feel concerned about intake of dietary pattern influence on fetal growth				
32	I feel satisfied with the fetal growth				
33	I still enjoyed with talking with the fetus.				
34	I feel concern about health of the fetus				
35	I feel satisfied in keeping baby things ready				
36	I feel anxious about the sex of the baby				
37	I feel comfort when fetus makes movement / awake.				

I.	**ADAPTATION TO SOCIO- ECONOMIC STATUS**					
38	Are you satisfied with your present living condition?					
39	Do think you are financially stable?					
40	Could you manage the family and the treatment expenditure within the family income?					
41	Do the members of your family help and support in financial aspect?					
42	Do you get any loan or borrowed money for the treatment?					

Muha;r;rp gbtk;

tbtikf;fg;gl;l Neh;fhdy; gbtk;

gFjp 1 : kf;fs; njhif fzpg;gpay; rhh;e;j Gs;sptptuj; jfty;

FwpaPl;L vz;:

1. taJ

m. 19-22 taJ [ ]

M. 23- 26taJ

,. 27-30 taJ

<. 31-35 taJ

2. fy;tp jFjp

m. fy;tp gapyhjth; [ ]

M. mbg;gil fy;tp

,. eLj;ju fy;tp

<. gl;ljhhp

3. kjk;

m. ,e;J [ ]
M. fpW];Jth;
,. ,];yhkpah;
<. kw;wit

4. njhopypd; epiy

m. jw;NghJ njhopy; nra;jy; [ ]
M. jw;NghJ Ntiyapd;ik
,. ,y;yj;jurp
<. tpahghuk;

5. FLk;g tif

m. $l;Lf;FLk;gk; [ ]
M. jdpf;FLk;gk;
,. nghpa FLk;gk;

6. khjhe;jpu FLk;g tUkhdk;

m. &. 1000-2000 [ ]
M. &. 2001-4000
,. &. 4001-6000

7. cq;fSf;F MjuT mspf;ff;$ba egh;

ahNuDk; cs;shh;fsh?

m. Mk;
M. ,y;iy

Mk; vdpy; Fwpg;gpLf _____

gFjp 2:-
<u>kfg;NgW gw;wpa jfty;</u>

1. jhapd; fh;g;gfhy taJ

m. 28-32 thuq;fs; [ ]

M. 33-36 thuq;fs;

,. 37-40 thuq;fs;

2. fh;gk; jhpj;j vz;zpf;if

m. 1 [ ]

M. 2

,. 3

3. jpl;lkpl;L fUj;jh;j;jPh;fsh

m. Mk; [ ]

M ,y;iy

4. cq;fs; fh;gj;ij vg;NghJ gjpT nra;jPh;fs;?

m. 6-8 thuq;fs; [ ]

M. 8-10 thuq;fs;

,. 10-12 thuq;fs;

<. 12-14 thuq;fs;

5. fh;g;gfhyj;jpd; NghJ Kjy; Neh;fhdy; vg;NghJ Nkw;nfhz;Bh;fs;

m. 6-8 thuq;fs; [ ]

M. 8-10 thuq;fs;

,. 10-12 thuq;fs;

<. 12-14 thuq;fs;

6. cq;fspd; fh;g;gk; rk;ke;jkhf the;jp / kaf;fj;jhy; mtjpg;gl;Bh;fsh?

m. Mk; [ ]

M. ,y;iy

7. Ke;ija kUj;Jtk; / my;yJ mWit rpfpr;ir gpd;tpisT ,Uf;fpwjh

(cly; ey Fwpg;Ngl;by;; ,Ue;J jftiy vLj;jy;)

8. jw;Nghija fh;g;gk; rhh;e;j gpd;tpisT ,Uf;fpwjh

(cly; ey Fwpg;Ngl;by;; ,Ue;J jftiy fz;lwpjy;;)

9. fh;g;gfhy guhkhpg;G gw;wp MNyhridapy; fye;J nfhz;Bh;fsh?

m. Mk; [ ]

M. ,y;iy

gFjp – III

t.vz;	nghUslf;fk;	typikahf Xg;Gnfhs;Sjy;	Xg;Gnfhs;Sjy;	cWjpaw;wepiy	Xg;Gnfhs;shik
m.	**jha;ik jd;ikapd; jw;Nghjpa epiy**	(5)	(4)	(3)	(2)
1.	vd; jha;ik jd;ikapd; cWjp epiy				
2.	ehd; jha;ik mile;jij jpUg;jp milfpNwd;				
3.	ehd; xU mk;khthf-jhahf cWjpahf ,Ug;Ngd;				
4.	ehd; mk;khthf- jhahf epidj;J ghh;j;jhy; gjw;wk; milfpNwd;				
	gpwe;j Foe;ijia guhkhpf;Fk; $Ljy; nryit				

5.	vd;dhy; rkhspf;f KbAk; vd cWjpaspf;fpNwd; gpwe;j Foe;ijia ehd; ed;whf guhkhpg;Ngd; vd cWjpaspf;fpNwd;				
6.	vdJ Foe;ijf;F jha;g;ghy; nfhLf;f Kbahky; ,Ug;gjhy; ehd; ftiy milfpNwd;				
7.	**<u>Ra xj;Jf;nfhs;sy;</u>** vd;id ehd; ed;whf ftdpj;J nfhs;fpNwd; vd jpUg;jp milfpNwd;				
M.	tajhy; vd; fh;gj;jpw;F VNjDk; ghjpg;G				
8.	Vw;gLkh vd;w vz;zk; cs;sJ ehd; ,we;JtpLNtNdh vd gak; ,Uf;fpwJ				
9.	ehd; NghJkhd vil tsh;r;rpAld; ,Uf;fpNwd; vd; MNuhf;fpaj;jpy;				
10.	ed;whf cs;Nsd; NgWfhyj;jpw;F gpwF vd;Dila cly;thF jpUk;g				
11.	ngwkhl;Nld; vd;w ftiy ,Uf;fpwJ				

12.	**czh;T Gh;tkhd <LghL**				
13.	vd; kdepiyf; Nfw;g ehd; Fog;gk; milfpNwd; Jhf;fkpd;ikahy; ehd; kpfTk; Nfhgg;gLfpNwd;				
,. 14.	vdJ fh;g;gfhyk; vg;nghOJ KbAk; vd kpfTk; Nfhgk; nfhs;fpNwd;				
15.	**jpUkz cwT** vd; fh;gj;jpy; vdJ fzth; <Lghl;lhy; jpUg;jp milfpNwd;				
16.	vd; fzth; xU ey;y mg;ghthf ,Ug;ghh; vd ek;gpf;if cz;lhfpaJ				
< 17.	vd; Jizthplk; thf;Fthjk; nra;Ak;NghJ Nfhgg;gLNtd;				
18.	cly; cwtpd; NghJ gpurtk; MfptpLNkh my;yJ Foe;ij ghjpg;Gf;Fs;shFNkh vd gjw;wk; ,Uf;Fk;				
19.	**Jiz mikg;G** ahuhtJ xUthplk; ghJfhg;ig czh;fpwPh;fsh?				

20.	njhlh;e;J cjtp Ntz;Lk; vd;why; vdf;fhf kf;fs; ,Ug;ghh;fs;				
c.	vd;id Nerpf;fTk; ghJfhf;fTk; ahNuDk; xUth; ,Uf;fpwhh;				
21.	rKjha eltbf;ifapYk;> Nfspf;ifapYk; <LgLtPh;fsh?				
22.	cq;fs; czh;Tfis NtW ahUldhtJ gfph;e;Jf;nfhs;tPh;fsh?				
23.	vdf;F kpfTk; Ntz;lg;gl;ltUld; njhlh;G nfhs;s trjp cs;sjh?				
	cld;gpwg;Gfs;				
24.	Kjy; Foe;ij ftdpg;gJ gw;wp ftiy milfpNwd;				
25.	Vdf;F mLj;j Foe;ij te;jhy; mjdplk; NghJkhd md;Gk; guhkhpg;Gk; ju ,aYk;				
26.	Gjpjhf gpwf;Fk; Foe;ij gw;wp Kjy; rpWth; khw;wkiljy; fz;L mk;kh gjw;wkiljy;				
C.	**jha; - Nra; xg;Gik**				
27.	jha;ikapdhy; cz;lhFk; cly; gUkid Fwpj;J vd;				

	vz;zk;				
28.	rj;Jkpf;f czT rpRit tsh;r;rpahf;Fk; vd;w vz;zk;				
29.	fU tsh;r;rp Fwpj;J jpUg;jpahf cs;Nsd;				
	fUtpy; cs;s Foe;ijAld; NgRtJ gw;wp ehd; milAk; re;Njh\k;				
v.	fU tsh;r;rp gw;wp ehd; ftdkhf ,Uf;fpNwd;				
30.	Foe;ijapd; nghUs;fs; jahh; epiyapy; ,Ug;gij fz;L jpUg;jp milfpNwd;				
31.	rpRtpd; ghypdk; vd;dthf ,Uf;Fk; vd;W gakhf cs;sJ				
32.	rpRtpd; mirT kw;Wk; tpopg;gpd;NghJk; ehd; nrsfhpakhf czh;fpNwd;				
33.	**<u>nghUshjhu xg;Gik</u>**				
	jw;Nghija tho;f;if epiy Fwpj;J jpUg;jp milfpNwd;				
34.	nghUshjhu hPjpapy; epiyahf cs;Nsd;				
35.	FLk;g tUkhdj;jpy; kUj;Jt nryit rkhspf;f				

	Kbfpwjh ? cq;fs; FLk;g 36. cWg;gpdh;fs; nghUshjhu hPjpapy; cjTfpwhh;fsh? 37. kUj;Jt nryTf;F fld; VjhtJ thq;fp cs;sPh;fsh?				

MODULE

COPING WITH PSYCHOSOCIAL ADAPTATION IN PRIMI GRAVIDA MOTHERS

- The ability of the pregnant women involving or relating to the social and psychological aspect of present aspects.

STRESS REDUCTION

- Listening to music
- Spend time to talk with your fetus
- Do meditation for 15minutes/day either in morning or evening

ACCEPTANCE OF PREGNANCY

- Be confident in ability to cope with pregnancy
- Feel satisfied being expectant mother

- Be concern about your health

DIET MODIFICATION

- Avoid fasting and skipping meals
- Have nutritious diet
- Improve eating habits by 5-6 times/day
- Drink adequate quantity of fluids 2.5 to 3 liters/ day

MENTAL PREPARATION

- Make good use of leisure time
- Participate in activities which is enjoyable
- Share your feeling with one who takes care of you.

MAINTAIN EMOTIONAL STABILITY

- Develop positive attitude towards pregnancy
- Adequate rest for 2 hrs/day
- Keep quiet when you feel negative reaction

STRENGTHING FAMILY SUPPORT

- Identify a family member who can be readily available throughout the entire pregnancy
- Being physically present is not enough. Family members must try to know about pregnancy and if possible ways to support an expectant mother and also appear participative in nature.
- Exchange views about child rearing with your partner.
- Expectant mothers must be accompanied for prenatal visits, prenatal classes, tests during pregnancy and finally, for labour and delivery.
- Make sure to be with expectant mother during ‘big events’. For instance, when the first ultrasound comes or at the time when the unborn baby's first heart beat is

detected. The magic of these prenatal events becomes even more memorable when shared with loved ones.

- Being physically present is not enough. Family members must try to know about pregnancy and if possible ways to support her.